DEPARTMENT OF HEALTH FOR SCOTLAND
SCOTTISH HEALTH SERVICES COUNCIL

MATERNITY SERVICES IN SCOTLAND

Report by a Committee appointed by the Council

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*Member of the Professional Subcommittee

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APPENDICES

Maternity Services in Scotland

Chapter I. Introductory

1. We were appointed in June, 1956, (following an announcement by the Secretary of State in the House of Commons, on 20th March, 1956) as a Committee of the Scottish Health Services Council, with the following terms of reference:

> "To consider, through a professional subcommittee in the first place, the range of provision which should be available in the National Health Service in the interests of the mother and child during pregnancy, confinement and lying-in; and to advise how best such provision can be secured within the framework of the Service."

In appointing the Committee, the Scottish Health Services Council had in mind the recommendations made by the Committee of Enquiry into the Cost of the National Health Service which sat under the chairmanship of Mr. C. W. Guillebaud and *reported in January, 1956. The Guillebaud Committee found that there was evidence that the maternity services were in a state of some confusion and recommended that the reorganisation thereof should be reviewed at an early date.

2. At our first meeting, we decided to invite evidence from bodies representing the three parts of the National Health Service (the Regional Hospital Boards; the Scottish Association of Executive Councils; the Scottish Associations of Local Authorities); from professional bodies representing those engaged in the provision of maternity services (representatives of specialists and consultants; of general practitioners; of medical officers of health; of midwives; of health visitors; of almoners); and from bodies who could represent the mothers themselves (the Scottish Women's Rural Institutes and the Townswomen's Guilds). A list of the bodies giving written evidence is contained in Appendix I, while a list of the witnesses who were good enough to give oral evidence is contained in Appendix II. In addition, we heard evidence from Dr. C. A. Douglas and Dr. P. L. McKinlay of the Department of Health, who undertook to provide us with a paper showing the development of maternity services in Scotland, including a statistical summary of the trends which can be observed over the years. Unfortunately this paper proved much too comprehensive and in some respects too technical for inclusion in this Report. Nevertheless it contains scientific material which will be of great value to investigators in this field and, on this account, the Committee recommend that the Secretary of State might consider its publication separately. Our second chapter is therefore but a very brief outline of the historical development.

3. We thought it desirable that in the first instance the whole Committee, including the professional subcommittee, should consider the written evidence submitted, and have an opportunity of hearing the oral evidence taken at eleven meetings during 1957. We have summarised the evidence in our third chapter, trying to show the various points of view which have been put before us.

4. Next, the professional subcommittee turned to their special task of determining the range of provision which should be available within the National

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Health Service in the interests of the mother and child during pregnancy, confinement and lying-in. They reached broad agreement in a series of meetings and our fourth chapter outlines the facilities which they consider should be available.

5. It then remained for the Committee as a whole to consider what steps could and should be taken to secure the provision of these services within the framework of the National Health Service. Our fifth chapter contains the results of these further deliberations, and we conclude with a sixth and final chapter, summarising our main recommendations.

6. It should be added that (while our Report is a Scottish Report, based on the evidence we have received from Scottish bodies and Scottish witnesses, and having regard to the special features distinguishing the development of maternity services in Scotland) there has been a regular interchange of information with the Committee under the chairmanship of the Earl of Cranbrook who have been considering the maternity services in England and Wales, with terms of reference very similar to ours and based also on the recommendations of the Guillebaud Committee. Our range of evidence has been from broadly comparable bodies; we arranged for an exchange of papers, so that we have been able to make use of the Cranbrook Committee's summaries of oral evidence of bodies, such as (for example) the National Association for Maternal and Child Welfare who submitted identical evidence to the two Committees. We also held two meetings, one in London and one in Edinburgh, with the Cranbrook Committee.

We have been particularly fortunate in our secretaries and acknowledge our gratitude to them. In particular we wish to mention Dr. Mabel E. Mitchell, who in addition to her general duties as our medical secretary, maintained liaison with the Cranbrook Committee and has given us the benefit of her expert knowledge and personal experience of maternity and child welfare work.

Miss L. C. Watson has been responsible for all our administrative arrangements. She undertook personally the preparation of summaries of evidence, most of the initial drafting and has supervised the passage of the Report to its final stage.

Miss K. E. McGregor made full reports of all our meetings and provided information, often at short notice.

To these ladies we express our deep appreciation of all that they have done on our behalf.

Chapter II. The Maternity Services in Scotland

8. The turn of the century saw increasing official concern with the well-being of mothers and young children. From the Report of the Royal Commission on Physical Training (Scotland) in 1903 came the institution of a system of school medical inspection; the subsequent Notification of Births Act, 1907, gave local authorities who adopted it an opportunity to obtain information as a basis for measures to reduce the high infant mortality of the period. The Notification of Births (Extension) Act, 1915, empowered all local authorities to make such arrangements as they thought fit and as might be sanctioned by the Local Government Board for Scotland, for attending to the health of expectant and nursing mothers and children under five years of age; the Midwives (Scotland) Act, 1915, gave the local authority powers and duties for the general superintendence of midwives.

9. The schemes which local authorities were required to submit to the Local Government Board included the provision (in conjunction with voluntary

institutions and agencies available in their areas) of maternity centres, home visitation by health visitors, hospital provision for cases of complications of pregnancy and lying-in and for sick children, day nurseries or nursery schools, and the provision of schools for mothers in mothercraft, simple cookery and child care. At that time there were more than 150 local authorities responsible for maternity and child welfare; the Local Government (Scotland) Act, 1929, reduced this number to the present 55, being the councils of counties and of large burghs. That Act also brought important changes in the financial relations between central and local government in this and other fields. The previous percentage grant system, which included a 50 per cent grant for maternity and child welfare, was replaced by the general grant, while the powers and duties of the new maternity and child welfare authorities were extended to include the reorganisation of the hospital facilities at their disposal and the power to provide hospital accommodation for all classes of sick and for maternity cases.

10. At the time when the *Cathcart Committee were reviewing the health services in Scotland, the latest available figures (for 1934) showed that there were some 1,000 beds for maternity purposes in local authority and voluntary hospitals. Subsequently, the general policy of the Department of Health for Scotland concentrated on the provision of a midwifery service which would make expert obstetrical care readily available as widely as possible. All local authorities were asked to provide comprehensive schedules in respect of every maternal death; the result was the assembly of statistical information which was annotated and commented upon in the Report by Dr. C. A. Douglas and Dr. P. L. McKinlay on Maternal Mortality and Morbidity in Scotland, published in 1935, and which dealt with about 2,750 of these schedules. The main findings of the Report became the basis for the Maternity Services (Scotland) Act, 1937; this statute differed notably from the corresponding Midwives Act, 1936, for England and Wales, in requiring the local authorities in Scotland to provide not only the services of midwives (either employing them directly or indirectly through a nursing association) but also the services of general practitioners, specialist obstetricians, and anaesthetist help where necessary.

11. The Second World War (occurring before these arrangements were fully operative) brought a new feature in the shape of emergency maternity hospitals for expectant mothers evacuated to reception areas from the areas likely to become targets for enemy action. Suitable houses were adapted temporarily to serve as emergency maternity hospitals, obstetricians were placed where they were needed throughout the country, and while most, though not all, of the hospitals subsequently reverted to their peace time uses, the result was a considerable strengthening of specialist resources. Indeed, the developed maternity services, together with the additions provided during the war, formed a workable pattern for maternity hospital and specialist services which was ultimately inherited and developed by the Regional Hospital Boards under the National Health Service.

12. Before the introduction of the National Health Service, maternity services were mainly in the hands of the local authorities—whether hospital, general practitioner or midwifery services—except that the main obstetrical teaching schools were, of course, associated with voluntary hospitals. A comprehensive form of record, used by midwives and general practitioners, was available to the medical officers of health and the local authority, and also to the hospital if necessary, and served as a claim form on which payment was made to the general practitioners by the local health authority. In many areas there was thus complete unity of control, particularly in those areas where the authority had their own maternity hospital accommodation, and a very close

*See Report on the Health Services in Scotland, Cmd. 5204 of 1936

co-operation between doctor, midwife and obstetrician was developed. With the advent of the National Health Service, in 1948, the three parts of the service for all purposes came under separate administrative authorities.

13. The maternity medical services of the general practitioners became the responsibility of the 25 Executive Councils, who pay the fees where the general practitioner undertakes a confinement in a general practitioner hospital or unit as well as his fees for ordinary domiciliary cases, although they are not responsible for the fees of doctors called in by midwives in emergency, which latter fees remain the responsibility of the local health authorities as local supervising authorities under the Midwives Acts. The hospital and specialist services were transferred to the five Regional Hospital Boards who took over some 2,700 maternity beds from local authorities and voluntary hospitals. The local health authorities retained direct responsibility only for the provision of a domiciliary midwifery service, including their existing powers and duties in the supervision of midwives, and for the provision of care for expectant and nursing mothers and young children, including the provision of clinics. All these services became available without charge under the National Health Service, whereas there had formerly been charges (frequently remitted in whole or in part) both for hospital accommodation and for the services of the midwife and of the general practitioner.

14. A memorandum stressing the need for co-operation between the three parts of the service was issued by the Department of Health towards the end of 1948, and reference will be made later to its detailed provisions (see Chapter III). It is sufficient to note that where there was experience of unified control under the Maternity Services (Scotland) Act, 1937, the transition was effected without difficulty.

15. A table of statistical information (drawn principally from the Department's Annual Reports and the Registrar General's Reports) in Appendix III shows for each year from 1948, the births coming within the scope of the maternity services (any still outside the service are so small in number as to be negligible), the live birth rates per 1,000 population, the proportion of the births which have taken place at home, the medical staff available and the visits paid by mothers to local health authority clinics (figures for hospital clinics are not available). The table also shows the numbers of hospital beds available for maternity cases over the years, with a concentration in the cities and large towns. The table concludes with figures showing the progress in the reduction of the rates of maternal mortality and of infant mortality, which continues the trends already established before the introduction of the National Health Service.

Chapter III. Broad Summary of the Evidence

16. We asked the bodies whom we consulted to give us their views on the whole subject of our remit. In summarising their views, we have found it convenient to take a chronological sequence, beginning with antenatal preparation and education and continuing to the final post-natal examination.

THE ANTENATAL PERIOD

Notification of Pregnancy

17. Those who laid most stress on antenatal medical supervision and education in parentcraft and hygiene, pointed out that if full use were to be made of existing services early knowledge of pregnancy was essential. Until it was known

that a woman was pregnant, none of the resources of the existing services could be made available to her. The Scottish Branch of the Society of Medical Officers of Health, and the Scottish Health Visitors' Association advocated some form of notification of pregnancy to the medical officer of health, at the sixth month or earlier. In this they were supported by the Association of Counties of Cities. Where a woman had booked with a local health authority midwife, the Scottish Branch of the Society of Medical Officers of Health suggested that the transmission of information to the health visitor who would be concerned with health education was a matter of internal arrangement. Where the midwife was in private practice, they thought that she should be under an obligation to notify the case forthwith to the medical officer of health for transmission to the appropriate health visitor. It might be useful, they suggested, to have pregnancy reportable to the local health authority by the hospital, if the woman first attended there. The Scottish Health Visitors' Association, indeed, pointed out that it was the woman attending a hospital antenatal clinic who was most likely not to be known to the local health authority until her child was born. The problem is one which has most relevance to the mother having her first child, and it is to be remembered that at present this constitutes about a third of the total births. We asked some of our other witnesses for their views, but found no unanimity of opinion.

A Code of Good Practice for Antenatal Work

18. Several bodies thought that it would be desirable that there should be a recognised code of good practice in antenatal medical supervision. The Scottish Branch of the Society of Medical Officers of Health said that in domiciliary midwifery the meaning of antenatal supervision should be definitely laid down; for example, with a statement of the minimum number of examinations considered necessary; and that there should be specific mention of the necessity for making routine blood tests and haemoglobin estimations. The witnesses of the Scottish Branch of the Society agreed, however, that the standard of antenatal examination was essentially a part of accepted medical education, which must be subject to constant revision and was essentially a professional matter. One of them suggested that the Committee might recommend that some form of code should be laid down by some suitable body, for example, the Royal College of Obstetricians and Gynaecologists. The Scottish Health Visitors' Association thought that general practitioners did not always find it convenient to carry out all the routine tests and thought it essential that the statutory minimum number of antenatal examinations should be higher than at present. The Glasgow Obstetrical and Gynaecological Society suggested also that more should be required of the general practitioner than the two antenatal examinations mentioned in his terms of service: the standard of care should be similar, they thought, to that given by hospitals and local health authorities. The Scottish Association of Executive Councils, on the other hand, pointed out that while the two examinations referred to in the general practitioner's terms of service were mentioned as essential examinations, they were not intended as a statutory minimum. The obligation of the general practitioner was to render all proper and necessary treatment and in practice to fulfil this obligation he made many more examinations than these mentioned. They suggested that as the position did not appear to be understood outside the general practitioner services, and many bodies were under the misapprehension that two examinations fulfilled a general practitioner's statutory obligation, the practitioner's obligations might be clarified in the terms of service. Their witnesses agreed that the clarification might be combined with an increase in the number of examinations said to be essential. The Royal Faculty of Physicians

and Surgeons of Glasgow took the same point about the inadequacy of the statutory requirements, and so did the Association of Counties of Cities, the Association of County Councils in Scotland, the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists, and, by implication, the Scottish Board of the Royal College of Nursing, who suggested that additional examinations should be undertaken after the thirtieth week, with a view to detecting the development of possible complications. The Scottish Council of the British Medical Association, while regarding the examinations mentioned in the terms of service as statutory requirements, said that they bore little relationship to the actual care given by most general practitioners; 90 per cent of them were, the witnesses of the Association thought, doing more, and if a minimum were laid down, the danger might be that it would be accepted at its face value. They said that they understood that the two examinations had been laid down with special reference to the conditions of payment; some mothers might not summon a doctor until a comparatively late stage in the pregnancy, and it was thought desirable to ensure that a doctor who, for this reason, could not undertake more than two examinations, should not lose financially. They said, however, that they thought that the ideal would be to abolish conditions of payment, and pay for adequate services, and they undertook to consider further how this could be achieved. Their further evidence on this point reiterated their opinion that the statutory requirements were inadequate and should be increased. They thought that normal antenatal services would consist of a monthly examination from the date of first attendance to the seventh month and thereafter an examination every two weeks, or more frequently, if occasion demanded. They did not, however, envisage that these services should be regarded as obligatory, in the sense that payment might be challenged if such visits were not recorded; they suggested rather that where such a scheme of examinations was not carried out and there was no note of explanation from the practitioner, the case should be referred to the Local Medical Committee for consideration of the fee to be paid. The Association of County Councils in Scotland suggested that under the Maternity Services (Scotland) Act, 1937, the medical officer of health had been in a position to require a minimum as a condition of payment: they mentioned also the desirability of the presence of the general practitioner at the confinement (see separate section on this below in paragraph 30). The Medical Women's Federation (Scotland) in their evidence, laid down what they thought should be provided, including early diagnosis of those medical conditions which, in association with pregnancy, increase the risks; early and skilled assessment of the type of confinement to be expected; skilled diagnosis of abnormal presentations and position of the foetus in the later months, and of foetal abnormalities; adequate antenatal visits to ensure the early diagnosis of the toxaemias of pregnancy; and laboratory services for blood testing and bio-chemical and bacteriological investigation.

Co-operation between General Practitioner and Midwife

19. There was general agreement on the need for close co-operation between general practitioner and midwife in domiciliary practice, and the frequency with which it was advocated perhaps reinforces the statements made from some quarters, e.g., by the Scottish Branch of the Society of Medical Officers of Health, that in some cases there was insufficient co-operation: they suggested that it would be desirable to lay down more detailed co-ordinating arrangements to ensure that both played their part without duplication. The North-Eastern Regional Hospital Board also suggested that in some cases in the country districts the work was not well correlated. The Scottish Council of the Royal College of Midwives said that the mother should make arrangements as early as possible

with both doctor and midwife, so that they could decide between them how best the mother's antenatal care could be carried out. Their witnesses said that where co-operation had been achieved through the Maternity Services (Scotland) Act, 1937, the introduction of the National Health Service had in no way lessened this, though the whole structure was now more cumbersome. They stressed that it was most desirable for doctor and midwife to see the patient together where possible. The Royal Colleges of Edinburgh and the Edinburgh Obstetrical Society suggested that co-operation would be encouraged if both doctor and midwife used the facilities of local health authority clinics (this is in line with other suggestions which are separately noted below in paragraph 23). The Scottish Association of Executive Councils commended the description in the Cathcart Report of doctor and midwife acting together: and their witnesses told us that in Aberdeenshire and Kincardine, general practitioners had been asked to inform the district nurse-midwives of pregnancies, though this was mainly in order that mothercraft training could be undertaken. This is the pattern recommended, too, by the National Association for Maternal and Child Welfare, who emphasised that when a woman is to have a home confinement (there being no social or medical or obstetric contra-indication) she should be booked by both general practitioner obstetrician and midwife, who should make reciprocal arrangements for her care. The Medical Officer of Health of Paisley told us that in his area there was full interchange of information between practitioner and midwife, the midwife keeping notes which were easily accessible; and in this area, if a woman first reports to a local health authority clinic, she is to be referred to her doctor, who, if a domiciliary confinement is decided upon, gives a form to be sent to the public health department for the services of a midwife. Reinforcing the general emphasis on the importance of this essential co-operation and the proper sharing between practitioner and midwife of antenatal care, the witnesses of the Central Midwives Board for Scotland mentioned the difficulty which arose if this co-operation were lacking, when a midwife might find that she had to attend a confinement with no previous knowledge of the obstetric history.

" *Midwife Alone* " *Cases*

20. Many of the bodies giving evidence referred specifically to the admitted possibility that a woman might now engage a midwife only, without a medical practitioner. The Glasgow Obstetrical and Gynaecological Society thought that antenatal care should not be undertaken by a midwife working alone. The Scottish Association of Executive Councils suggested that the formal schemes for maternity services which they would like to see worked out for each local health authority area by all three parts of the National Health Service should contain a provision that every expectant mother, whether she was to be confined at home or in hospital, should be under the care of a general medical practitioner: their witnesses suggested that admission to hospital should, normally, be arranged only on a doctor's recommendation, as with medical and surgical cases, and this is a suggestion taken up in other contexts considered below. The Royal Faculty of Physicians and Surgeons of Glasgow regarded the possibility of " midwife alone " cases as a retrograde step. The Scottish Council of the British Medical Association said that in this respect they thought that the Maternity Services (Scotland) Act, 1937, had been much preferable: their witnesses thought that the doctor might be held responsible for seeing that arrangements were made with the midwife. The Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists strongly concurred; their witnesses said that while few women did in fact book a midwife alone, it often happened that the midwife was left to bear the full responsibility; they thought that this was equally undesirable.

The Medical Staffing of Local Health Authority Antenatal Clinics

21. There was general agreement among the bodies giving evidence that the local health authority clinics, or, in areas where there were no clinics, the district nurse-health visitors should be responsible for parentcraft teaching and for health education, which is of especial importance at a time when mothers are most likely to be receptive to it. There was much criticism, at the same time, of the medical staffing of local health authority clinics, and particularly of the impossibility of providing for the desirable continuity of medical care between the antenatal period and the confinement, since the local health authority maternity and child welfare officers could not, from the nature of their employment, take responsibility for the confinement. It was recognised that some of these officers were fully experienced in obstetrics when they took up their appointment, but it was inevitable that they should cease to continue to have first hand experience of more than the antenatal medical supervision, even if some arrangement could be made for them to interchange with hospital staff. The Scottish Council of the Royal College of Midwives were of the opinion that the staffing of local authority antenatal clinics by these officers was one of the weakest links in the service; they thought it should cease and their witnesses suggested that an obstetrician should be in charge. From other bodies we learned that other arrangements could be and were made; the Eastern Regional Hospital Board, for example, said that hospital medical staff worked at all local health authority clinics; the Glasgow Obstetrical and Gynaecological Society instanced Motherwell as an area in which the local health authority clinic was run by the hospital obstetrician; the North-Eastern Regional Hospital Board said that consultant obstetricians were made available at local health authority clinics, and their witnesses thought that it might be desirable that an obstetric consultant should have a part-time appointment on the staff of the medical officer of health; the Northern Regional Hospital Board said that in their region, local health authorities did not participate in the provision of antenatal clinics to any extent, and their witnesses said that they realised that the Board were undertaking more than they needed to do, but they had been anxious to continue in operation arrangements which had been working smoothly when they took over. The Western Regional Hospital Board suggested that the clinical care of patients attending local health authority clinics should be undertaken by hospital medical staffs. The Royal Colleges of Edinburgh and Edinburgh Obstetrical Society, the Royal Faculty of Physicians and Surgeons of Glasgow, the Central Midwives Board for Scotland, the Association of Scottish Hospital Matrons, and the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists all pointed to the importance of continuity of medical care, and suggested that the local health authority medical officer should gradually be replaced in antenatal clinics by the general practitioner or by hospital staff. The Scottish Association of Executive Councils thought that no clinical duties should be carried out by local health authority medical officers, and their witnesses suggested that they thought that this was important in the interests of continuity of care, though they suggested also that general practitioners should be able to refer patients to clinics for blood tests, as well as for parentcraft and health education. The Scottish Council of the British Medical Association thought the local health authority medical officers were no longer necessary in antenatal clinics, and the Scottish Council of the College of General Practitioners implied that their recommendation that the family doctor should be responsible for antenatal care, if accepted, ruled out the use of local health authority medical officers. Witnesses from Glasgow Corporation, on the other hand, felt strongly that local health authority medical officers could provide instruction and a link with the family background, which the general practitioner might not always be in a position to provide: they had an arrangement

with the Western Regional Hospital Board whereby the Board took part in the selection of these officers and the Board made a contribution to the Corporation towards their salaries. Witnesses from the Association of Counties of Cities suggested that hospital staff might work in local health authority clinics, and that there might be some interchange of staff between hospital and clinic; they suggested also that general practitioners might refer patients to clinics for blood tests as well as for education. Witnesses from the British Paediatric Association commended the combined clinical service provided in Aberdeen by paediatric consultants and child welfare medical officers and suggested that the local health authority medical officers would tend in the future to concentrate more on paediatrics.

Antenatal Supervision of Women booked for Hospital and living at a distance

22. If continuity of medical care is to be preserved wherever possible, women booked for hospital confinement ought, so far as possible, to receive their antenatal supervision from the hospital. This may be impossible because of distance in country areas and various suggestions were made to us for overcoming these difficulties. The Scottish Council of the Royal College of Midwives thought that the necessary continuity could be secured if the women were to attend a local authority clinic, at which a hospital obstetrician and midwife could attend, so that there could be full exchange of information among those concerned. The Scottish Branch of the Society of Medical Officers of Health, and the Scottish Health Visitors' Association, as well as the Association of Counties of Cities all suggested that, apart from the initial and concluding examinations, intermediate antenatal examinations might be locally conducted at clinics. The witnesses of the Society of Medical Officers of Health agreed that alternatively antenatal supervision could, in these circumstances, be carried out by the general practitioner. The representatives of the South-Eastern Regional Hospital Board told us that patients made their own way to clinics at the central hospitals, which were well attended, and they thought that either by ordinary means of transport, or through the fairly liberal interpretation which the Women's Voluntary Services give to the medical reasons justifying the use of the hospital car service, there was no undue difficulty for the women who had to travel to the central clinics. It should be noted, however, that a representative of the Scottish Women's Rural Institutes, who was also a voluntary worker in a Midlothian clinic, told us that there was in fact a good deal of hardship to the women in making long journeys to the central clinics: she thought that arrangements for intermediate examinations to be carried out at local clinics, either by the women's own general medical practitioners or by the local health authority's medical officer, would be welcomed, if that could be arranged, particularly if hospital staff could also be available at the local clinics in a consultant capacity. This sort of arrangement is in fact in operation in several areas. Thus, the representatives of the North-Eastern Regional Hospital Board told us that in peripheral clinics in Aberdeen County consultative clinics were held, although such arrangements had not been universally welcomed by general practitioners. Representatives of Glasgow Corporation told us that one of the objects of the Corporation in providing antenatal services at local clinics had been to avoid unnecessary travelling for mothers, though at present there was a good deal of cross-traffic, in that mothers booked for hospitals might pass local clinics on their way to attend a hospital antenatal clinic. A sharing of antenatal supervision between hospital and general practitioner was suggested by the Royal Faculty of Physicians and Surgeons of Glasgow, the Medical Women's Federation (Scotland), the Scottish Council of the British Medical Association (who cited the excellent arrangements in Perthshire as an example of what could be

done with full co-operation), the Scottish Council of the College of General Practitioners, the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists and the Association of Scottish Hospital Matrons. The Scottish Branch of the Queen's Institute of District Nursing thought that more area consultant obstetricians should be appointed to attend antenatal clinics in outlying areas, so that they would be able to see women booked for hospital. This arrangement in fact obtains in many areas.

The Local Health Authority Clinic as a Meeting Place for the Medical Interests

23. All the foregoing suggestions had a wider application than merely to women booked for hospital confinement. The Scottish Council of the Royal College of Midwives, for example, the Royal Colleges of Edinburgh and Edinburgh Obstetrical Society and the Association of County Councils of Scotland, were all in favour of affording general practitioners the facilities of local health authority clinics, and the Scottish Board of the Royal College of Nursing (who were among those who advocated a list of general practitioner obstetricians) said that they thought that general practitioner obstetricians could well be introduced into the local health authority antenatal clinics.

Appointments Systems at Clinics

24. Several bodies suggested that appointments systems should be adopted in all hospital and local health authority clinics. The Scottish Branch of the Society of Medical Officers of Health, the Scottish Health Visitors' Association and the Association of Counties of Cities all made this point. Representatives of the South-Eastern Regional Hospital Board told us that appointments systems were used in some of their central clinics, but they thought that some mothers preferred to come early and meet their neighbours. It appeared from other witnesses that there was in fact considerable enthusiasm for appointments systems and some grumbling at the long waiting that was inevitable when such systems were not in operation, but that mothers were hesitant to complain. The Medical Officer of Health of Paisley told us that an appointments system had been introduced for mothercraft instruction of groups of mothers at the local health authority clinic.

THE CONFINEMENT

Place of Confinement

25. Several of the bodies who gave evidence suggested that there was room for the encouragement of confinement at home in suitable cases. The Scottish Council of the Royal College of Midwives told us that women were apt to demand hospital confinement because the Press and other organs of publicity had suggested that it was safer. In the opinion of the witnesses of the College, this view was exaggerated; they told us that they thought that some general practitioners were too ready to advise hospital confinement, and also that they understood that women were apt to seek a definite hospital booking, because they feared that if they were admitted at the last moment in an emergency they might be discharged too quickly. The Scottish Board of the Royal College of Nursing suggested that over the country as a whole a figure of 50 per cent of hospital confinements would meet the needs of the maternity service, adjustments being needed in particular areas; their witnesses thought that patients should have freedom of choice, but they said that specialists were helping to foster a belief in the safety of hospital confinements. The Central Midwives

Board for Scotland suggested that more women could safely be delivered at home, provided that clinical and social conditions were satisfactory, and suggested that this would relieve pressure on beds and ensure a longer stay in hospital for those who needed it; one of their witnesses said that there were many advantages to be obtained from a domiciliary confinement, provided that the home conditions were satisfactory: the acceptance of hospital confinement as a general rule was resulting in women being discharged before they were completely fit. Witnesses from the Scottish Branch of the Queen's Institute of District Nursing similarly deprecated the trend towards hospital confinement and said that home confinement was safer than it had ever been: provided medical and social conditions were satisfactory, they saw no reason why a mother should not be safely confined at home; this was the view also of the National Association for Maternal and Child Welfare. Witnesses from the Association of Scottish Hospital Matrons expressed their reluctance to discharge women on the third, fourth or even so early as the sixth day, because of shortage of beds. On the side of the general practitioners, there was a considerable amount of opinion in favour of domiciliary confinement for various reasons. The Scottish Association of Executive Councils urged selective booking for specialist units; they suggested that further provision of general practitioner units would secure continuity of attendance by the family doctor in cases unsuitable for domiciliary confinement because of social conditions, and would reduce the size of specialist maternity units, which at present were accommodating many normal cases and were at the same time frequently discharging women too early. The Scottish Council of the British Medical Association thought that the proportion of hospital confinements was too high in some areas and the Scottish Council of the College of General Practitioners also favoured more domiciliary confinements. Various reasons for the trend towards hospital confinement were suggested. The Northern Regional Hospital Board thought that it was based on current and perhaps evanescent fashion; their witnesses thought that the fashion had been little affected by the increase in the home confinement grant, and that the avoidance of domestic upset was a more important consideration than safety. Other witnesses from Regional Hospital Boards also mentioned convenience to the family and rest for the mother as reasons for the popularity of hospital confinement, as well as lack of help in the home. (The use and availability of the home help service of the local health authorities are considered separately below in paragraph 33.) The Scottish Regional Committee of the Institute of Almoners said that the majority of women preferred hospital confinement; one of their witnesses said that she thought that women felt safer in hospital, and that even a short stay in hospital was regarded as better than none. The Association of County Councils in Scotland were good enough to make available to us the results of a local survey carried out in Dunbartonshire, in 1955 and 1956, which showed that only 31 per cent of women having their first baby preferred to be confined at home; though 59 per cent of women having their second or later confinements preferred to be at home. Of those with experience of both types of confinement, 75 per cent preferred home confinement, though mainly so that they could be with their families, and of those with experience of only one type, only 7 per cent wished to change for future confinements. It was emphasised in the paper that the number investigated, though covering over 1,000 cases, was too small to allow firm conclusions to be drawn, but the sample was of considerable interest. We were much interested, too, in the efforts made by a representative of the West of Scotland Federation of Townswomen's Guilds to obtain for us first hand accounts of the maternity services from women who had used them. The representative of the Scottish Women's Rural Institutes, while disclaiming any right to speak for the Institutes as a whole, told us that general practitioners invariably advised women having their first babies to go to hospital; she thought that some of them would prefer home confinement

and that they could suitably have been confined at home. The Scottish Branch of the Queen's Institute of District Nursing summed up most of the reasons given in various places for the trend towards hospital confinement; they said it was due to (*a*) excessive propaganda from hospital specialists stressing greater safety; (*b*) lack of suitable housing in certain areas; (*c*) insufficiently developed or insufficiently flexible home help services; (*d*) economy to the mother, and this in spite of the increase in the home confinement grant; and (*e*) encouragement by general practitioners, sometimes irrespective of medical, obstetric or social need.

26. Just as there was diversity of opinion on what the choice should be, there was divergence of opinion on the extent to which a choice should be available in those areas, mostly in the Western Region, where the proportion of hospital confinements is considerably less than the 70 : 30 proportion for the whole of Scotland. The Royal Colleges of Edinburgh and the Edinburgh Obstetrical Society considered that the ultimate aim should be to provide obstetric beds for all who needed or desired hospital confinement; at the least there should be provision for all who needed it on medical or social grounds. This was also the view of the Royal Faculty of Physicians and Surgeons of Glasgow. The Medical Women's Federation (Scotland) thought that beds should be available for (*a*) abnormal obstetric cases, (*b*) social cases, (*c*) primigravidae and (*d*) every expectant mother desiring a hospital confinement; a list not unlike that of the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists, who suggested that beds should be available for all those who desired or required them, with priority for (1) abnormal cases, (2) primigravidae, (3) women with fifth or later deliveries and (4) women needing admission on social grounds. The Association of County Councils also thought that beds should be available for all women desiring hospital confinement, but the Association of Counties of Cities thought that it was sufficient to cover the obstetric and social needs of each area, and laid special stress on the need for the investigation of social priorities by the medical officer of health. Thus, generally, even bodies who wished to encourage domiciliary confinement also thought that it was desirable that a woman should have her choice, but it was recognised that this might perhaps leave an area of choice rather wider than ought to be available in the mother's own interest. The witnesses of the North-Eastern Regional Hospital Board, for example, reminded us that even with their proportion of 80 : 20 hospital confinements not all women from poorer households with larger families were in fact confined in hospital. Many of them were anxious to be confined at home because of family ties. Several of the bodies giving evidence also drew attention to the need for more antenatal beds, particularly for women with toxaemia or anaemia and for multiple pregnancies.

Problems of Over-booking through Shortage of Beds

27. From various quarters, it was suggested that shortage of beds led to problems of over-booking. Witnesses from the Western Regional Hospital Board told us that it was their practice to give firm bookings on medical grounds and on social grounds, but when these did not fill the available beds, they made provisional bookings. The result was that women in this last group might have to be refused at the last moment, when they might have made quite inadequate preparation for domiciliary confinement. This was confirmed by witnesses from Glasgow Corporation, and from the Glasgow Obstetrical and Gynaecological Society, the latter suggesting that these refusals were, in effect, due to over-booking in the first place and inadequate integration of the facilities for hospital and domiciliary confinement. Many bodies, for example, the Scottish Branch of the Society of Medical Officers of Health, the Scottish Health Visitors'

Association, the Scottish Association of Executive Councils, the Association of County Councils in Scotland, the Scottish Council of the British Medical Association and the Association of Scottish Hospital Matrons, suggested a more selective system of booking, which could at least secure priority of admission for women requiring it on medical and social grounds. The South-Eastern Regional Hospital Board complained that lack of central guidance on the categories which should be accorded priority gave them difficulty in planning. The Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists summed up by suggesting that there should be priority for specified groups, with a margin for possible closure of wards and for emergencies, and that the obstetrician in charge should decide on admission, so that a booked patient should be assured of her bed.

Length of Stay in Hospital

28. A ten day period of stay in hospital after delivery was widely regarded as suitable. We were told that discharge seven to eight days or even less after delivery was fairly common, and this was regarded as too short a stay. Early discharge was deprecated as either providing inadequate nursing for the mother, or placing an undue load on the domiciliary services, even when it was possible to make good arrangements for close co-operation. The Medical Officer of Health of Paisley told us, for example, that the average stay in hospital in that area was about seven days. He said he was finding difficulty in recruiting domiciliary midwives and the need to attempt adequate supervision for the remaining seven days of the recognised period of the midwives' responsibility for women who had been discharged from hospital on the seventh day made his task even more difficult. Witnesses from the Scottish Council of the Royal College of Midwives said that mothers who left earlier than the tenth day were not so happy or so confident, and it was not so easy to establish breast feeding in a shorter period. The Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists on the other hand, thought that with present shortages of beds, more admissions and shorter stay might be preferable, if perfect co-operation with the domiciliary services could be effected. The British Paediatric Association, while noting, as did other bodies giving evidence, that short stay discouraged breast feeding, suggested that it might be useful to undertake a pilot experiment in very early discharge from hospital.

General Practitioner Units in Hospital

29. The provision of more general practitioner units was suggested by several bodies. Throughout the country, particularly in the Northern and North-Eastern Regions, there are small hospitals staffed by general practitioners, which provide a number of obstetric beds as well as medical and surgical beds. There are also maternity hospitals, or obstetric units in general hospitals, where beds are set aside for the use of general practitioners; for example, the Queen Mary Maternity Home in Edinburgh has been taken over by the Regional Hospital Board and is run in conjunction with the Simpson Memorial Maternity Pavilion, general practitioners being responsible for their patients in the Home, calling on consultant advice as necessary, while the nursing staff is provided from the Simpson. In some general practitioner units, the consultant from the hospital to which the unit is attached makes it a rule to see all patients on admission, though the general practitioners remain generally responsible. As might be expected from this diversity of types, some witnesses regarded general practitioner units as mainly providing an alternative to domiciliary confinement for uncomplicated cases, particularly, it was suggested by the Scottish Association of Executive Councils, for those requiring hospital confinement merely

because of unsuitable home conditions, and therefore as being more or less independent of hospital control, except to the extent to which the practitioners themselves sought consultant advice; while others regarded general practitioner units more as an extension of hospital facilities for normal cases which should be closely linked with a principal obstetric unit. The Standing Committee of the Royal College of Obstetricians and Gynaecologists said that if ever 100 per cent hospital confinement were to be obtained, there must be an adequate proportion of general practitioner units. The Medical Women's Federation (Scotland) thought that general practitioner units would meet many of the difficulties of domiciliary midwifery. The Scottish Council of the British Medical Association wished such units to be available, either in specialist hospitals, or in separate establishments, the general practitioner summoning consultant advice if necessary. The Scottish Council of the College of General Practitioners sought a substantial increase in maternity beds at the disposal of the general practitioner and envisaged transfer of beds for this purpose.

The General Practitioner's Part in Domiciliary Confinement

30. While every woman is entitled to obtain maternity medical services from the general practitioner of her choice, there is no obligation on the practitioner to be present at the delivery, or even at the confinement unless he thinks it necessary. Several bodies, for example, the Royal Faculty of Physicians and Surgeons of Glasgow, the Scottish Council of the British Medical Association, the Scottish Council of the College of General Practitioners (in oral evidence) and the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists thought that a doctor should be present at the delivery, whether that took place at home or in hospital. There was a suggestion from various quarters that some women went to hospital, instead of being confined at home, because they were afraid that their doctors would not be present at the delivery in the latter case, but we gathered from the evidence mentioned above that it was not the usual practice in hospital either, though consultant advice was, of course, always available. The general view might be taken as that expressed by the witnesses of the Medical Women's Federation (Scotland) that the doctor's presence at the delivery was optimum practice, but that it was scarcely a matter that could be made obligatory.

The Desirability of Instituting a List of General Practitioner Obstetricians

31. Admission to the list of general practitioners offering maternity medical services has been unrestricted in Scotland, though witnesses from the Scottish Association of Executive Councils told us that when selecting practitioners to fill vacant practices, Executive Councils would to a large extent require proof of adequate obstetric experience. The institution of an obstetric list, on the lines followed in England and Wales, was advocated by the Scottish Branch of the Society of Medical Officers of Health and looked forward to as an ideal by the Royal Colleges of Edinburgh and Edinburgh Obstetrical Society, and by the Royal Faculty of Physicians and Surgeons of Glasgow. The Glasgow Obstetrical and Gynaecological Society reported a general feeling that general practitioners engaged in obstetrics should furnish proof of adequate experience, and the Medical Women's Federation (Scotland) suggested that general practitioners practising midwifery should possess the D.(Obst.)R.C.O.G., or alternatively should have held a house appointment in a recognised obstetric hospital, or otherwise have good obstetric experience. The North-Eastern Regional Hospital Board stressed the importance of obstetrical experience in a house officer post in a maternity unit of a hospital, and said that if this view were accepted, the

logical sequence would be the eventual restriction of obstetric work to practitioners having special post-graduate training in the subject. The Scottish Association of Executive Councils and the Scottish Council of the College of General Practitioners were opposed to the introduction of an obstetric list, as were the witnesses of the Scottish Council of the British Medical Association. Those in favour of a list pointed to the growing inadequacy of under-graduate experience in midwifery, and suggested that it would not be long before newly qualified medical practitioners had practically no experience in midwifery. The basis of the opposition was that the family doctor should be in a position to undertake obstetrics for all his patients who wished him to do so, and that this was incompatible with an obstetric list. In discussion, note was also made that there were many areas in Scotland in which there was no choice of doctor, so that it might be necessary to make some exception to the qualifications required, in view of the possible difficulty of obtaining suitably qualified practitioners for those areas. On the other hand, it is fair to say that witnesses from the Northern Regional Hospital Board, for example, were satisfied that doctors appointed to isolated areas had usually reasonable obstetric experience before appointment.

Post-graduate Experience and Refresher Courses for General Practitioners undertaking Maternity Medical Services

32. Other bodies, without actually advocating the introduction of an obstetric list, stressed the importance of adequate post-graduate experience in obstetrics. The witnesses of the Northern Regional Hospital Board, for example, made this point. The Scottish Council of the Royal College of Midwives, the Central Midwives Board for Scotland, and the Association of Scottish Hospital Matrons all suggested that general practitioners undertaking midwifery might be required, or encouraged, to take refresher courses at intervals. In this they no doubt had in mind the present provisions under which midwives must take refresher courses at stated intervals.

Home Help Service

33. The domestic help service of the local health authorities is available both for the woman confined in her own home and also to look after the family of the woman being confined in hospital. The service is now available in all areas, but its development varies. Criticism of the service was made by many of the bodies giving evidence, and it was suggested that if the service were more flexible, and less expensive, it would be more freely used and might encourage domiciliary confinement. A 24-hour service for ten days was suggested, both by the Medical Women's Federation (Scotland) and by the Scottish Council of the British Medical Association. It was agreed by the witnesses of the Scottish Association of Executive Councils and of the Association of County Councils in Scotland that a reduced charge for maternity cases might be helpful. The difficulty of defending any such reduction as against other equally deserving cases was, however, generally recognised, as was the difficulty of obtaining a sufficient number of suitable women to provide the number of home helps who would be needed if the service were to be used on a very much larger scale than at present.

Availability of Consultant Facilities for Home Confinements

34. In emergencies in domiciliary confinements, hospital and specialist facilities, including flying squads with facilities for blood transfusion, are readily available in all areas. The Eastern Regional Hospital Board, for example,

told us that all their consultant obstetricians were available for visits to the homes of patients who could not visit hospitals or clinics, and 83 such visits were paid in 1955. The North-Eastern Regional Hospital Board said that their policy had been to develop a series of peripheral consultative clinics: their witnesses told us that it remained the responsibility of the family doctor to decide at what stage advice should be sought, but that where good co-operation had been achieved, it had been found that better results were obtained, in avoidance of stillbirths and neo-natal deaths, when adequate specialist supervision was available. The Scottish Council of the British Medical Association mentioned that general practitioners should be able to obtain an opinion only and others took the same point, but there seemed general agreement that this was no longer to any great extent a difficult issue: with so great a demand for hospital accommodation, it was not likely that patients would be retained unnecessarily, and only in the exceptional case where it was necessary in the interests of the patient, to prevent her becoming seriously ill, would she be retained in hospital rather than referred back to her practitioner with a report. The prinicipal reason for suggesting that the general practitioner unit should be associated with a maternity hospital or large obstetric unit in a general hospital was to facilitate easy access to consultant advice, but it was evident that questions might arise on the point at which such advice should be sought.

The Effect of Increased Use of Hospitals on the Domiciliary Midwifery Services

35. Mention has already been made (in paragraph 28 above) of the burden placed on the domiciliary midwifery services, which are the responsibility of the local health authorities, by the need to continue the supervision of women discharged from hospital very soon after confinement. The South-Eastern Regional Hospital Board pointed out also that the efficiency of the domiciliary services depended on continuing opportunity to practise being offered to those engaged in domiciliary midwifery. If the number of cases should fall below a certain level, the domiciliary service would not be able to maintain its present high standard of efficiency. One of the reasons for the suggested institution of a list of general practitioner obstetricians was that it was thought desirable that the diminishing number of domiciliary confinements should be divided among a smaller number of practitioners so as to keep up their efficiency. The North-Eastern Regional Hospital Board told us that with the present organisation of general practice in the cities, they thought it unlikely that any one doctor or group of doctors would retain sufficient midwifery for this purpose, and the witnesses of the Medical Women's Federation (Scotland) said that older practitioners were concerned that the shortage of domiciliary cases meant that newly qualified doctors had insufficient obstetric experience. Bodies concerned with the training of domiciliary midwives spoke of difficulties in arranging for the practical training of pupil midwives and suggested that insufficient experience after training affected the skill of the midwife, just as it did the skill of the doctor. Witnesses of the Scottish Branch of the Queen's Institute of District Nursing suggested that if midwifery ceased to be part of the duty of a district nurse, recruitment would suffer; and a witness from the North-Eastern Regional Hospital Board with experience of local health authority problems told us that the lack of any domiciliary midwifery apart from antenatal and post-natal visits to women who had been confined in a hospital was frustrating to experienced district nurse-midwives. From obstetricians came the suggestion that domiciliary midwifery might become a hospital responsibility, which would allow some interchange of midwives between domiciliary and hospital services. Several bodies spoke of difficulty in recruiting midwives, and the Scottish Council of the Royal College of Midwives, the Central Midwives Board for

Scotland and the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists all mentioned, as a contributory factor, the merging of maternity units in the general administration of a larger hospital, leaving midwifery administration no longer autonomous. Mention was also made of the fact that a trained nurse who became a pupil midwife was paid less than she would have heen paid as a staff nurse.

Parentcraft and Health Education

36. So far we have been concerned principally with obstetric and medical requirements, hut we were left in no doubt that the maternity service would be incomplete if it did not also provide for the instruction of mothers, both individually and in groups, in parentcraft and health education. This seemed to comprise at least three elements. There was first the preparation of the mother for childhirth, including a simple explanation of the physiology of pregnancy and labour; antenatal exercises in relaxation where these were thought to be desirable, instruction in the use of inhalational analgesia, preparation for the bahy and hreast-feeding. Then there was instruction to prepare the mother in the care of her haby and to help with its uphringing, which we were told was being widened to include parentcraft as well as mothercraft. Thirdly there was health education, which was generally regarded as having a special relevance and urgency when a new member of the family was being hrought into the world, so that much could hest be taught at a time when the mother was likely, for the most part, to be especially receptive to it. It was generally recognised that parentcraft and health education were pre-eminently the province of the local health authorities, with their duty to make arrangements for the care of mothers and young children, and with the facilities offered by their health visitors, midwives and nurses and their clinics. What difference of opinion there was related to the way in which this type of instruction could best be provided for women whose antenatal care, confinement and post-natal care were to he in hospital. The Scottish Branch of the Society of Medical Officers of Health suggested that local health authority medical officers and health visitors should he given access to hospital clinics for this purpose: one of thcir witnesses said that she recognised that mothercraft instruction was often already available at hospital clinics, but it might not be presented from the same angle as at local health authority clinics. Representatives of hospitals, on the other hand, while agreeing on the importance of this instruction preferred that it should be carried out by hospital staff trained for the purpose, and saw no danger that it would thereby acquire a pathological aspect. The Scottish Health Visitors' Association emphasised that the basic instruction must be individual teaching of the mother in her home by the health visitor, but that it could usefully be supplemented by group teaching, which made it easier to use visual aids, and enabled the mother to associate with other expectant mothers. Group teaching and individual teaching should, they said, he closely connected, and the group teaching should be undertaken by those who knew the mothers' home backgrounds, and could adapt their theoretical instruction to the conditions likely to be found in the mothers' homes. The extent to which adequate educational facilities are available varies from area to area. The Eastern Regional Hospital Board told us that they thought that educational facilities should be further developed. The North-Eastern Regional Hospital Board witnesses thought that the present position was perhaps not quite so good as it had been before the introduction of the National Health Service; it was adequate in the towns, hut there was a lack of facilities in the country areas, and direct access to hospital sometimes meant that a mother lost the opportunity for mothercraft instruction which had previously been availahle through local authority clinics. The Scottish

Association of Executive Councils regarded this kind of instruction as a function of the local health authorities which they were anxious to see continued and developed, and so did the Scottish Council of the British Medical Association. The Scottish Branch of the Society of Medical Officers of Health and witnesses from Glasgow Corporation thought that general practitioners might be encouraged, perhaps even required, to refer mothers to clinics for instruction, and witnesses from the Medical Women's Federation (Scotland), agreeing that the majority of general practitioners had insufficient time to attempt detailed instruction themselves, welcomed co-operation with local health authority clinics and health visitors. The British Paediatric Association suggested that greater attention should be paid to the normal and abnormal psychology of childbirth and their witnesses supported the extension of mothercraft to include parentcraft. We were glad to note that our witnesses who spoke for mothers themselves told us that facilities were available and had been welcomed.

AFTER THE CONFINEMENT: GENERAL ISSUES

Post-Natal Supervision and Examination

37. From all sides there was agreement on the importance of post-natal medical examination, carried out at from about four to six weeks after the confinement. In general, the suggestion was that post-natal care ought to follow the lines of antenatal care. The Medical Women's Federation (Scotland) suggested that instruction in family planning should be available at post-natal clinics.

Specialised Facilities which should be Available for the Maternity Service

38. Several of our witnesses drew attention to deficiencies in some of the specialised facilities which should be available in the maternity service.

DENTAL CARE. The Royal Faculty of Physicians and Surgeons of Glasgow drew attention to a grave lack of adequate dental care in maternity units, through shortage of dentists. The Association of Counties of Cities suggested a remedy for this, when they recommended that all antenatal clinics in hospital should allow members of the local health authority's staff to be present to arrange for various services within their sphere, including dental examination where necessary. We noted with interest that the Medical Officer of Health of Paisley, in describing the arrangements for closer co-ordination which are being brought into operation for the Burgh, mentioned that the clinic medical officers would arrange for dental examination, and that the representative from the Scottish Women's Rural Institutes told us that full use was made of the very good dental facilities which are available in the area with which she was most familiar. Other witnesses, for example those of the Medical Women's Federation (Scotland), recognised, however, that while the inadequacy of dental services for mothers and young children was one of the shortcomings of the service, it was largely due to the shortage of dentists. The British Dental Association told us that in their view the elimination of oral sepsis was of the first importance for the mother and her unborn child: their witnesses agreed that there was no direct evidence of the effects of oral sepsis in the expectant mother and in the unborn child, but they suggested that since calcification of the teeth began three months before birth and continued for three months after, the mother's health must be of supreme

importance. The Association said that general practitioners did not always refer mothers to available dental facilities; the dental facilities in maternity hospitals were in general inadequate; and the priority dental services provided by the local authorities were insufficient. They pointed out that some local health authorities were failing to provide a proper service, some of them still relying on an arrangement whereby they met the patient's share of the General Dental Service charge for the provision of dentures, although the Department of Health had indicated that this was not regarded as an adequate fulfilment of the statutory obligation, and the Association regretted that it was not possible for free dentures to be provided under the General Dental Service. Their witnesses agreed, however, that there were not enough dentists in the country to meet a hundred per cent. demand upon their services. It may be noted that the Scottish Council of the British Medical Association specifically mentioned in their evidence that the necessity for dental care and the availability of free dental treatment ought to be made more widely known.

Special Units for Premature Infants and Sick Babies, and the Association of Paediatricians with Maternity Units. The importance of specialised units for premature infants and for sick babies at all specialised maternity hospitals was stressed by several bodies, as well as the desirability of providing facilities for nursing them at home. Provision was needed in the hospital unit both for babies born in the hospital, and, separately, for admission from outside of babies with their mothers, and units should be under the care of a specialist paediatrician. Witnesses from the British Paediatric Association said that infants weighing under 4½ lbs. and any premature infants needing an incubator should be in hospital, but infants over 4½ lbs. might be better nursed at home if adequate nursing facilities were provided by the local health authority. This involved also special ambulance provision, with heated cots and arrangements for co-ordinating the movement of consultant and nursing staffs. Mention was made, also, of the importance of seeking the co-operation of paediatricians in all matters affecting the health of the infant before birth. The Association considered that a consultant paediatrician should be appointed to each maternity unit, and sufficient sessions allotted to enable him to visit at least once a week; with the obstetrician, he should advise on the prevention of illness and on the antenatal preparation for breast-feeding.

Laboratory Facilities. Among the many bodies who stressed the importance of adequate blood tests and other laboratory services, several suggested that the laboratory services at some obstetric units were meagre. The Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists thought that in a large maternity unit a 24-hour service was required and they and other bodies stressed also the need for research into the main factors of pre-eclamptic toxaemias, prematurity and congenital defects.

Specialist Anaesthetists. Both the Glasgow Obstetrical and Gynaecological Society and the Scottish Council of the College of General Practitioners said that specialist anaesthetists should be available for domiciliary confinements, and said that they were often difficult to obtain, though the witnesses of the Society agreed that it was sometimes also difficult to obtain them in hospital, since there were not enough of them.

Availability of Records

39. The importance of adequate and available medical records was frequently mentioned in the evidence; to ensure adequate continuity of medical care throughout a single pregnancy, to secure rapid and effective exchange of information between all three branches of the service, and to provide information for the assessment of results and for research. Witnesses of the Scottish Branch of the Queen's Institute of District Nursing, and of the Scottish Branch of the Society of Medical Officers of Health referred to the record card in use under the Maternity Services (Scotland) Act, 1937, which had been available to midwife general practitioner and hospital, and then remained with the medical officer of health, from whom the necessary history was thus available for the record of a subsequent pregnancy. It had also acted as a claim form, and it was because of this that the Association of County Councils in Scotland were able to say that, under the Maternity Services (Scotland) Act, 1937, the medical officer of health was in a position to require an adequate standard of antenatal supervision as a condition of payment (see paragraph 18 above). The Society of Medical Officers of Health thought that the present record form used by general practitioners providing maternity medical services should be revised, and they were anxious that in some way all completed records should be made available to medical officers of health to provide a pool of information for statistical and research purposes. Without such an arrangement cases could not be looked into. Representatives of practitioners and consultants referred to the need for securing an adequate exchange of information among those who were clinically concerned with a case. Witnesses of the Medical Women's Federation (Scotland) told us, for example, that difficulty had sometimes been experienced in obtaining access to records kept at local health authority clinics, which were often open only at limited times. Witnesses from Glasgow Corporation told us that record cards were filled in at their clinics and sent to the Regional Hospital Board, but they, and other witnesses, were inclined to agree that it might be useful to explore the possibility of extending a system in operation in the Stirling area (mentioned to us by the witnesses of the Scottish Council of the Royal College of Midwives) for a patient to carry her own record, a copy being sent to the general practitioner. We were told that in the Stirling area no mother had been found to be unduly alarmed by the clinical medical terms which she might find in the record; antenatal education had made them sufficiently familiar with what to expect: but other witnesses, e.g., those from the Glasgow Obstetrical and Gynaecological Society thought that if the patient carried a record, it should be sealed. Successful interchange of records was noted in many areas, notably in Perthshire, where, it was explained to us, contact was maintained between hospital and practitioner throughout a patient's pregnancy, the doctor sending his antenatal findings to the hospital and vice-versa, initial and final examinations being undertaken by the hospital. Witnesses from the Scottish Council of the British Medical Association emphasised that the family doctor should have full information at all stages, and they suggested that if a woman attended a clinic without a letter from her family doctor he should be informed. Witnesses from the Royal Faculty of Physicians and Surgeons of Glasgow pointed out the value of adequate records on reference to a consultant, to avoid duplication of tests already carried out. Regional Hospital Board representatives were agreed that some greater uniformity of record system could be introduced with advantage, and the witness of the Royal Colleges of Edinburgh and Edinburgh Obstetrical Society, who, in written evidence, had laid stress on the value of the systematic collection and review of records, suggested that each obstetric area—i.e., the area served by a major obstetric unit—might usefully consider the possibility of adopting a uniform record throughout the area. All three branches of the Service would be concerned, and the Scottish Association of

Executive Councils reminded us that if one branch of the Service was without important information in the possession of another, there might be increased danger of faulty handling in emergency.

Tripartite Structure

40. All three branches of the National Health Service have powers and duties in relation to maternity, and from the beginning of the service they have been advised and reminded of the need for co-ordination to ensure smooth working. In 1948, the Department of Health issued D.H.S. Circular No. 149/1948 (reproduced in Appendix IV) in which they asked each of the 55 local health authorities (the councils of counties and of large burghs) to be responsible for making available, in pamphlet form, information about the maternity services to be found in their areas—the doctors undertaking home confinements; the antenatal clinics; the midwifery, health visiting, home nursing and home help services; the hospitals providing for non-institutional confinements and the specialist services available for non-institutional confinements. The five Regional Hospital Boards, and the 25 Executive Councils responsible for arranging general practitioner and maternity medical services were asked to collaborate by providing the necessary information, and the Executive Councils were asked to make the pamphlets available to the general practitioners in their area. Subsequently Executive Councils were asked, in a later circular from the Department, to take the initiative in arranging for co-ordinating committees, representing all three branches of the Service, to facilitate day to day consideration of problems of co-ordination. These were not specifically designed to deal with the maternity service, but some of them found it useful to set up subcommittees on the subject. It seemed to us that any confusion which was to be found in the maternity service in Scotland was likely to be related to the tripartite structure of the Service, and we therefore raised this question with all our witnesses, coupling it with an enquiry whether, in their view, the present statutory powers were adequate to allow the development of a satisfactory service. All five Regional Hospital Boards found the structure reasonably satisfactory and such confusion as there might be not inherent in the tripartite administration. The Eastern Board suggested that the fact that they were coping with 80 per cent of the confinements in their region, showed that the system could work satisfactorily, though pressure on beds often involved short stay in hospital. The South-Eastern Board felt that the structure itself was not unsatisfactory, but they felt the need for more central guidance on the responsibilities of the three parts. The Western Board were prepared to admit the existence of confusion, in the shape of overcrowded hospitals and hospital clinics, but their witnesses stressed that in their view, shortage of beds and not the structure was at the root of their difficulties. The North-Eastern Board found no real confusion, only to some degree in the question of the general practitioner's responsibility for antenatal care in home confinements. The Northern Board said that the statutory powers available were adequate, but their witnesses were in favour of a single control under the Regional Hospital Board, which was also favoured by a few other bodies. The Association of County Councils in Scotland, and the Association of Counties of Cities, both found the structure adequate, but co-ordination lacking; the former suggested that local health authorities could provide the necessary co-ordination, though their witnesses were doubtful whether the other branches of the Service would accept this; in generally regarding the structure as adequate, they were supported by the Society of Medical Officers of Health, and the Scottish Health Visitors' Association, as well as by the bodies representing nurses and midwives, the Scottish Board of the Royal College of Nursing taking the point that there were gaps in the

Service, as well as examples of overlapping. The Scottish Association of Executive Councils also emphasised the presence of overlapping and lack of co-operation, and suggested as a remedy an obligation to co-ordinate. The Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists considered that the tripartite structure was not unrelated to the confusion which they thought did exist in many places, and suggested a single statutory authority. Their witnesses, however, echoed the views of the Western Regional Hospital Board, and the Corporation of Glasgow, that more hospital accommodation was more important than any alteration of the administrative structure. The Scottish representatives of the British Paediatric Association thought that a system of records available to all three branches of the Service might provide a partial solution: they thought facilities might be available which were not sufficiently utilised. The majority view of the Scottish Council of the British Medical Association was that the structure was satisfactory, but that machinery to secure co-operation was needed. The Scottish Council of the College of General Practitioners suggested that the general practitioner should be in a position to integrate the service. No dissatisfaction with the structure itself emerged from the evidence of the Scottish Women's Rural Institutes, or from the West of Scotland Federation of Townswomen's Guilds.

Co-ordination and Co-ordinating Committees

41. While there was thus an almost complete unanimity of opinion that improved co-ordination was needed, there was much variation in the methods suggested for securing it. The Scottish Association of Executive Councils proposed a system of submission of schemes, from the local health authorities, Regional Hospital Boards and Executive Councils in each local health authority area, with power to the Secretary of State to make a scheme in the absence of agreement. The Scottish Council of the Royal College of Midwives, the Scottish Board of the Royal College of Nursing, the Central Midwives Board for Scotland, the Scottish Branch of the Queen's Institute of District Nursing and the Association of Scottish Hospital Matrons recommended a co-ordinating committee for each clinical area; and in this, they had the support of the Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists, and the British Paediatric Association, who envisaged a triple system of advisory co-ordinating bodies. There would be a central advisory body, which might be a committee or subcommittee of the Scottish Health Services Council, and would advise the Secretary of State on matters of policy; there would be joint regional obstetric committees and also district or area advisory committees. The North-Eastern Regional Hospital Board suggested expert advisory committees at regional level, and this idea of expert advisory bodies was also favoured by other bodies, among them the Scottish Health Visitors' Association, who suggested that a professional advisory body might review the circumstances of maternal and peri-natal deaths, with a view to discovering points of weakness in the present services which could be remedied.

Chapter IV. Range of Provision

42. Under the terms of the remit from the Scottish Health Services Council, the Scottish Maternity Services Review Committee were asked " to consider through a professional subcommittee in the first place, the range of provision which should be available in the National Health Service in the interests of the mother and child during pregnancy, confinement and lying-in ". Arising from this, the professional subcommittee considered first the extent to which they should deal with specifically medical and clinical matters. Point was given to this discussion by the suggestions from some of the witnesses that there should be " a code of good practice " in obstetrics, that the Scottish Maternity Services Review Committee was an appropriate body to lay down such a code, and that this might be embodied in a directive from the Department. After discussion the professional subcommittee decided unanimously that the promulgation of directions as to clinical practice was not desirable or feasible, and for these reasons—

(*a*) A code of good practice of obstetrics already exists in standard text books, in instruction given to undergraduates in medical schools, and to midwives in training departments. Though the details of the instruction may vary from place to place, in general the instruction represents the informed opinion and practice of those who profess this subject as a specialty. The standard of instruction is maintained at an adequate level through inspection by the General Medical Council and by the Central Midwives Board respectively.

(*b*) After consideration, the professional subcommittee felt that they could not usefully add to the authoritative advice on clinical and medical matters already available.

(*c*) No government directive can replace teaching that is based on observation and research and which by its very nature, retains flexibility and the capacity for modification as new advances are established. Even if it were left to an expert body to embark on this task, such a directive could do no other than create an artificial separation between the art and science of obstetrics and other branches of medical knowledge.

43. The professional subcommittee considered that the undergraduate training in obstetrics does not afford sufficient experience to enable the newly registered practitioner to meet the exigencies of obstetrical practice. They were impressed with the view that the practice of obstetrics demanded a special skill, and should be undertaken only by doctors who have had some pre- or post-registration training in this specialty. They recommended, therefore, a form of obstetric list. This recommendation is developed further in Chapter V.

44. Antenatal provision medically should include confirmation of pregnancy; advice on the most appropriate place of confinement; regular clinical supervision increasing in frequency after the 36th week and inclusive of estimation of haemoglobin, ascertainment of blood group including Rhesus factor and regular estimation of blood pressure; examination of urine; regular recording of body weight; assessment of presentation and relative size of the head and pelvis. On the educative side, mothercraft is essential and exercises in relaxation may be desirable. The subcommittee had evidence that, though in general facilities existed for fulfilling these requirements, circumstances in different parts of the country might affect the convenience with which they could be obtained; obviously the circumstances must vary between the busy clinics and hospitals of the larger cities, with facilities for the speedy examination of large numbers of patients and for group teaching as compared with the facilities of the doctors' consulting rooms in more isolated areas. No central directive can

meet all variables, and the diversity of circumstances adds to the arguments in favour of regional and subregional professional committees whicb are developed further in Chapter V.

45. Under present regulations, a general practitioner is required to provide for maternity medical services, as for other medical services, all proper and necessary treatment, but only two antenatal examinations, at or about the 36th and 38th weeks, are specifically mentioned in addition to tbe initial examination. In practice, these three examinations have often come to be regarded as a sort of minimum requirement for purposes of payment, though the professional subcommittee were aware that many doctors provide a more extensive service. While anxious not to appear to prescribe for the first time a minimum requirement, they considered that it would be desirable to ensure that, where a working rule was necessary for purposes of payment, it should cover five visits, two of which should be in tbe last three weeks. It is not claimed that five visits represent the optimum. Indeed, if a general practitioner habitually restricted his services to these essential visits, it might become necessary for the Executive Council to consider whether all proper and necessary services were being provided. But it seemed to the subcommittee clearly desirable that reasonable professional latitude should be left to the practitioner.

46. The subcommittee also empbasised the value of an extension of consultant or specialist services for general practitioners wbo undertake domiciliary obstetrics. Specialist opinion is, of course, always available in cases of difficulty, but there is undoubtedly a border-line group of patients, not having normal pregnancies and yet not clearly abnormal, about whom the practitioner may well have concern. The subcommittee felt that there should be no difficulty in obtaining specialist cover for this group of patients, and that encouragement sbould be given to any arrangement wbereby these patients may be seen by the specialist with tbe practitioner without necessarily involving tbe patient in a hospital attendance.

47. Under existing contractual arrangements, tbe doctor is not required to attend the confinement unless he thinks it necessary or is called in by a midwife. The professional subcommittee were unanimous that it should be a requirement for the payment of the full obstetric fee that doctors sbould attend during labour. They also recommended attendance at delivery though they recognised that this would not always be possible, and that insistence on this migbt be unjust to the practitioner.

48. In the puerperium tbe present regulations require that the doctor should attend the patient within twelve bours after tbe completion of labour or as soon thereafter as practicable and as often as be considers necessary throughout a lying-in period of fourteen days. The post-natal services include an examination about six weeks after confinement. The professional subcommittee accepted the requirement for continuation of attendance for two weeks following confinement. They thought, bowever, that it sbould be required of tbe practitioner that be ensured the hand-over of his patients to the health visitor as well as arranging for a post-natal examination about the sixth week after delivery. Where practicable, this examination sbould be made by the doctor undertaking the confinement.

49. Tbe subcommittee bad no evidence to suggest deficiency in the arrangements for dealing with emergencies; indeed, tbe organisation of flying squads and emergency services presented a high degree of efficiency. The subcommittee emphasised, bowever, that arrangements for the transport of premature babies left something to be desired and drew attention to the evidence in this respect whicb had been submitted by tbe paediatricians. There appeared to be a strong case for the more extensive provision of portable incubators for use with the

ambulance service, and arrangements should be made for this apparatus to be kept in constant readiness.

50. The subcommittee were impressed by the need for improved recording of clinical information during pregnancy, confinement and lying-in. It is true tbat record cards exist at present and some of these appear highly satisfactory. The aim should be that all significant information obtained about a patient during pregnancy, lying-in or in the puerperium should be transmitted to the other two branches of tbe maternity service without delay to ensure that all information of value is readily available, particularly in emergencies. It had been represented, however, that in hospital as well as in general practice, arrangements for the filing and subsequent analysis of records were most inadequate, and in most cases non-existent. For example, before the introduction of the National Health Service most of the large maternity hospitals were accustomed to publish an annual report which went some way to meeting the need for a continuance of record. Since the introduction of the Health Service, however, it appears that the Regional Hospital Boards have not regarded the publication of reports as part of their duty, and that they have no obligation to provide funds for this purpose. In these circumstances, and particularly in the absence of money to pay trained registrars, annual reports from maternity hospitals have tended to lapse. In the mind of the subcommittee there was no doubt that adequate conscientious recording was vital to all aspects of the maternity service, whether hospital or domiciliary. There seemed to be no case for the introduction of a standard record card by the Secretary of State, but it was felt rather that consideration of a new record card for domiciliary confinement was desirable. The professional subcommittee urged that money should be made available through the Regional Hospital Boards for an extension of record departments to include those of the maternity hospitals.

51. The subcommittee considered the views which had been expressed on the importance of hospital confinements for various groups of women on medical, obstetric or social grounds. It was clear to the subcommittee that more antenatal beds were needed in many, if not most, areas. As to lying-in beds, their conclusion was to favour hospital confinement for:

(*a*) women with medical or obstetric conditions requiring hospital confinement;

(*b*) primigravidae;

(*c*) women with fourth or subsequent pregnancies;

(*d*) women requiring admission on social grounds,

and they thought that these should be regarded as the priorities, where available accommodation made it necessary to establish a system of priorities. They thought, however, that if maternity accommodation, which might include general practitioner units, could be provided to cover not less than 70 per cent of the total births in areas where the present proportion of hospital confinements was less than that, leaving as at present the areas where the proportion was already greater, there might be little need for systems of priority.

52. The subcommittee regarded it as desirable that a woman should first consult her family doctor as early as possible in her pregnancy, since, whether or not he would himself be undertaking responsibility for her confinement, he ought to be aware of her pregnancy, in his treatment of intercurrent illnesses for which she might have occasion to consult him. The aim would then be to secure that, whether her confinement was to be at home or in hospital, she should have at her disposal, through doctor and midwife, the full range of consultant and specialist facilities, as well as instruction in parentcraft and health education.

Chapter V. The Measures Necessary to Secure the Range of Provision within the Framework of the Service

" The Framework of the Service "

53. From the beginning, we contemplated that it would be necessary to decide, in the light of the evidence we obtained, whether there was some inadequacy in the actual provision, or whether we should be content to review mainly the organisation. When inviting written evidence, therefore, from the bodies concerned with the actual administration of the Service—the Regional Hospital Boards, the Scottish Association of Executive Councils and the Associations of Local Authorities—we asked them to consider, in addition to their evidence generally, three specific questions. These were:

(1) the extent to which they had found the statutory powers available under the National Health Service inadequate to empower the provision of all that was desirable;

(2) the aspects in which the machinery set up under the Act had proved inadequate or defective to provide the service which it was intended to provide; how far such defects might be due to divided responsibilities; and whether they had any views on steps taken, or which might be taken, to overcome them; and

(3) whether the criticisms of the powers and/or machinery were such as to make desirable further definitions of powers and adjustments of machinery, or whether it would be more profitable meantime to facilitate the development of divergent trends in different areas by leaving " trial and error " to show later the way to a more effective Service.

While we did not put the questions specifically to the professional and other bodies, we discussed them in the course of all evidence.

54. We did this because we took the view that we should clearly be failing in our duty if, being convinced by the evidence, we hesitated to recommend some change merely because it would involve a change in the framework of the Service. In the event, however, as the summary in Chapter III shows, we received only a few suggestions which went beyond the present framework, and we have not found it necessary to make any recommendations which do so.

55. This does not mean that we regard the maternity services in Scotland as incapable of improvement, or even of considerable reorganisation. We agree with the opinion of the great majority of those witnesses to whom we put the first of our three questions, that the organisation of the Service within the framework is as important as the adequacy of the framework if not, indeed, more important. The Association of County Councils in Scotland expressed the views of many of our witnesses, when they said in reply to our second question that the main difficulty at present is in regard to co-ordination, and said in reply to our first question, that, subject to this need for co-ordination, the statutory powers available should be adequate, with the goodwill of all concerned. Their remedy for defective co-ordination was, however, to use the local health authority as co-ordinating agents " so that the mother can look to one agency through which she can obtain all the necessary information in regard to the services which she will require under the various sections of the National Health Service ". We did not feel that this in itself would provide a complete solution. We found, indeed, a general tendency on the part of each of the three divisions of the Service to regard co-ordination as something which should fall in their special province, which perhaps explains some of the " confusion " which undoubtedly has tended to arise.

56. The essential prohlem is the perennial difficulty of reconciling a reasonahle uniformity with a reasonable allowance for necessary local divergencies. If we examine the local choices which must be considered, we may hope to see how the reconciliation can be attempted.

The Choices Inherent in the Framework

FOR THE MOTHER

57. A woman who wishes to avail herself of the maternity services provided under the National Health Service can, at present, go in the first instance to a general practitioner, or to a midwife either directly or hy application to the health department of the local health authority; or to a local health authority clinic providing antenatal services; or to a hospital clinic providing such services. In theory, there are areas in which she could use all these facilities, collecting as much advice as she could, and she might add to it advice from a health visitor, if she happened to be in touch with one. It would have to be decided thereafter whether her confinement should be at home or in hospital and here her choice would in some areas be restricted hecause the number of available maternity beds makes it necessary for some kind of priority system to be estahlished. In the contrary sense, her choice might be restricted because, though she herself wished to be confined at home, her doctor or midwife might consider, on examination, that she ought to he referred to hospital, because of medical considerations; or the doctor or midwife might find that her home was unsuitable for confinement and that admission to hospital must be sought on social grounds. If neither of these restrictions applies, the mother desiring to be confined can, at present, if she chooses, engage a midwife only, though the midwife is bound hy the rules of the Central Midwives Board for Scotland to summon medical aid in certain defined circumstances. If the mother also wishes to engage a doctor, her choice may be restricted in that her family doctor may not undertake to provide maternity medical services, although since 2,418 out of the 2,575 general practitioners in Scotland in mid-1957 did provide maternity medical services, this is not a considerable restriction in most areas.

FOR THE MIDWIFE

58. The midwife is bound by her rules (D. 13) to advise her patient to seek medical advice or to take advantage of any antenatal services available in the area, and in particular, to urge her to suhmit herself for medical examination at as early a stage in her pregnancy as possihle. She must also in specified circumstances urge her patient to seek medical advice, and she must notify the Local Supervising Authority forthwith on the form prescribed should the patient refuse or neglect to follow her instruction to seek such advice. In addition, she must call to her assistance the patient's medical practitioner, whenever she becomes aware of any abnormal condition. Over and ahove what is laid down in the rules, it is usual for the local health authority, as the employer, to expect the midwife to see that a woman consults a doctor, whether a general practitioner or a local authority medical officer. In the last resort the midwife may find herself forced to undertake responsihility for the confinement alone, though she is always bound to call in a doctor in the event of ahnormality, hut there is usually ample opportunity for her to persuade the mother to make arrangements with a doctor.

FOR THE DOCTOR

59. A general practitioner is not hound to provide maternity medical services. But any general practitioner whose name is included in the Medical List of an Executive Council may provide such services to a woman whose name is included

in his list of patients. If, in his agreement with the Executive Council, the general practitioner has indicated his willingness to provide maternity medical services, his name is included in a special maternity medical services part of the Executive Council's Medical List and he may provide such services to any woman who applies to him and not only to women whose names are included in his list of patients. A doctor who is not on the maternity medical services part of the Medical List but provides maternity medical services to a patient on his own general medical list is paid at 5-7ths of the rates payable for corresponding services given by doctors who provide maternity medical services. It is understood that in England, where special lists of general practitioner obstetricians are maintained, the higher rate of payment made to these doctors is regarded as being related to the conditions to be fulfilled before entry to the obstetric list is granted. In Scotland, where any doctor is included in the maternity part of the Medical List who indicates his willingness to give maternity medical services, it would appear that the higher rate of payment is to be related to his willingness to consider giving maternity services to any woman who applies to him and not only to women on his own general medical list. While a general practitioner is not obliged to provide maternity medical services in any particular case, he is bound by the terms of his service to give his patients such advice and assistance as would seem appropriate to enable them to take advantage of the local health authority services and maternity medical services. While he is not bound by his terms of service to satisfy himself that his patient has engaged a midwife, we were informed that most doctors considered it to be a part of a practitioner's responsibility to see that arrangements were so made. This should be done early in pregnancy, and we should like to stress the importance of this practice. General practitioners in some areas have access to maternity beds. They can assume responsibility for their patients' confinements in a hospital and they will then, in most of the smaller hospitals of the cottage hospital type, exercise their own discretion as to calling in a consultant or transferring their patients to a specialised maternity unit. In larger general practitioner units, they may be under a general obligation to arrange for examination by a consultant on admission.

FOR THE LOCAL HEALTH AUTHORITY

60. In clinics staffed by local authority medical officers, women are accepted in some areas only on reference from a general practitioner; in other areas, all women who present themselves for antenatal examination and advice are accepted, though the general practitioner is not always informed. Normally clinic medical officers assume responsibility for assuring themselves that adequate arrangements are made for the confinement, and sometimes the clinic serves as an out-patient department for a maternity hospital, when a woman has been able to arrange to be confined there, and reports are then sent to the hospital. The clinic may, in other words, be comparatively self-contained, or it may have close links both with general practitioners and with the hospital service.

FOR THE HOSPITAL

61. Some hospitals require a reference, either from the woman's doctor, or sometimes, as an alternative, from a local health authority clinic. Other hospitals give a booking to all women who present themselves for antenatal examination and advice regardless of medical and social circumstances; such a hospital cannot always honour their bookings for a variety of reasons. Refusal of admission at the last moment often leads to domiciliary confinement for which no adequate preparation has been made and responsibility falls to a doctor or midwife not fully conversant with the case. We heard of no hospital in which

real difficulty was found in arranging for the admission of women who needed to be confined in hospital because of medical considerations. We found, however, that there were areas, particularly in the West of Scotland, where firm bookings were given only on clearly proved social need, leaving many cases of less urgent need to provisional bookings, which might be upset by the necessary admission of emergencies. This often leads to refusal of admission at the last moment, with inevitably a domiciliary confinement for which no adequate preparation may have been made.

The Extent to which these Choices should be Extended or Restricted

62. As is shown in our summary of evidence in Chapter III, several of our witnesses referred to the smooth working of the Maternity Services (Scotland) Act, 1937, in the areas where it was fully adopted. It was not in fact adopted in Glasgow or Dundee. At first sight it seems obvious that problems of choice must have been greatly simplified where a single authority was in control of midwife, general practitioner and specialist and consultant services, particularly in those areas in which the local authority had their own maternity hospital. The service, however, did not invariably cover all births; it did not directly cover maternity cases in nursing homes for example, except to the extent that the authority were responsible for the supervision of maternity and nursing homes and of midwives. Thus the application of the service was no more uniform than the application of the present National Health Service. For example, in some areas, the local authority themselves did not provide hospital or specialist services but made arrangements for this with voluntary hospitals.

63. Few of our witnesses, however, went so far as to advocate a single authority as the cure for problems of co-ordination and while we have considered the possibility, it seems to us rather to present a new series of problems of organisation, and of co-ordination with the rest of the National Health Service in its present form, from which any re-organised maternity service under a single authority, even if that authority were one of the three parts of the Service, must inevitably be divorced. We prefer to consider more closely the choices we have outlined, and see to what extent they could or should be extended or restricted.

64. The Mother's Choice. The picture we have drawn of the mother's choice takes little account of the existing fabric of the welfare state as we have it now. There are, after all, some 2,500 general practitioners in Scotland, with an average of some 2,000 patients on their lists. The maximum number of patients a practitioner may have on his list is 3,600 (4,600 for a partner provided the partnership average does not exceed 3,600) and many have much smaller lists. A young woman having her first baby in 1958 will probably have been on the list of a general practitioner for ten years. She may know whether he undertakes maternity medical services, and if he does and she wishes to have her baby at home, the probability is that she will consult him; if he does not, she can and probably will ask his advice, or she may know of a local practitioner who does undertake maternity medical services and go to him directly. She must go to a doctor or a midwife, if for no other reason than that she requires a certificate of pregnancy before she can claim maternity benefit from the Ministry of Pensions and National Insurance. (True, there were in Scotland in 1957, about 900 cases where a midwife alone was booked, and where the midwife would give the certificate of pregnancy, but the number of these cases has decreased markedly since the introduction of the National Health Service, and we should expect it to decrease further. The remedy lies in the hands of the midwives who can, with the encouragement of their employing authority, almost always persuade their patients to consult a general practitioner. This is a point which we have mentioned earlier and to which we shall return later.)

65. But though nowadays a woman is more likely to go to her general practitioner, she may yet wish to exercise a freedom which she still has in other branches of the National Health Service, and use the two other parts of the Service—the local health authority, in the shape of the clinic, or the hospital.

66. As regards the local health authority clinics it is important to remember their origin. They were established to provide skilled medical advice and treatment for women who, not being themselves insured persons, had not ready access to general practitioners; and often, also, to supplement the advice which general practitioners gave. Not all medical practitioners were prepared to give detailed instruction and advice on the management of pregnancy, preparation for labour and mothercraft training. The clinics and the work of the maternity and child welfare medical officers filled a gap which much needed to be filled, and in the days when some of the local health authorities also provided their own maternity hospitals, maternity and child welfare medical officers could and did combine work in the clinics and work in hospitals, so assuring the continuity of medical care, to which so many of our witnesses attached importance. With the transfer of hospitals to the Regional Hospital Boards, this arrangement became the exception rather than the rule, although it was always the intention that the closest possible relationship should continue between hospital and local health authority staffs.

67. Even where this close relationship is achieved, however, it merely restricts the woman's initial choice to two, instead of three, sources of advice. She may still go to her general practitioner and also go to the clinic or hospital. Is it desirable that she should, or ought the clinic or hospital to refuse to accept her as a patient without a reference from a general practitioner? This is not a question which affects only the maternity services. It arises, for example, in connection with all out-patient departments of hospitals, and the tendency seems to be to limit the choice, by encouraging reference from a general practitioner as the normal channel. It can be argued that this deprives a woman who has not the financial resources to go outside the National Health Service of the possibility of seeking further advice if she is not satisfied with what she has. But there must be limits to the extent to which it is reasonable to encourage such freedom. We have made it clear, in Chapter IV, that we do not favour an attempt to shackle professional freedom to develop new methods and techniques by trying to lay down some code of good practice for antenatal examination, or any other part of the maternity services. Nevertheless it seems to us that it is unreasonable to expect that a woman could really profit by obtaining divergent advice from different sources. The good general practitioner, the good local authority medical officer, the good medical officer in a maternity hospital clinic, are not likely to differ fundamentally in their advice, though they may differ in detail. One may be more likely to favour hospital confinement than domiciliary confinement, other things being equal; one may be more likely to advocate breast feeding and so on with a wide range of topics in which there is still a healthy divergence of opinion. As it seems to us that much of the confusion in the maternity services is related to the many choices provided and the risk of lack of continuity of medical care, we think that a primary requirement is that one person should be regarded as the co-ordinator. We believe this should be the general medical practitioner. Accordingly *we recommend it should be the responsibility of the general practitioner to provide or secure the provision of all the facilities required by the mother during pregnancy, confinement and lying-in, and we make this our first recommendation.* (Recommendation 1).

68. In saying this, we should like to emphasise that in our view the good general practitioner would never hesitate to refer his patient to a consultant, or to a clinic, if he felt that she would thereby be given confidence. This is, after all, the general basis of relationship between patient, general practitioner and

specialist and consultant services and we should like to see it fully established here. But there could be many variations in the relations between general practitioners, local health authority clinics and the hospital services as will be considered later.

69. We consider, too, that where a woman has not consulted her general practitioner, but has presented herself direct to a local health authority clinic, hospital clinic, midwife, general practitioner obstetrician (as defined later) or consultant, it should be their duty to inform the general practitioner, if the woman has not already done so, unless she objects to this. As the professional subcommittee showed, in Chapter IV (paragraph 52) this is important both because he might be summoned in case of intercurrent illness, when he ought to know of the pregnancy, and because this is often the time when a general practitioner is first consulted by his patient, and it can afford an opportunity for establishing relationships which may be of great value.

70. THE CHOICE OPEN TO THE DOCTOR. In Scotland as we have seen, a general practitioner has not been required to show that he possessed special qualifications in obstetrics before he was admitted to the list of general practitioners willing to provide maternity medical services. Any doctor in the area of an Executive Council may apply to be placed on the maternity medical services list. This implies that in Scotland maternity medical services are regarded as falling within the skill of a general practitioner and that he is himself competent to provide " all proper and necessary treatment ".

71. In England and Wales, a medical practitioner wishing to have his name included in the obstetric list makes application to a local obstetric committee, who review the obstetric experience of the applicant, and if they are satisfied, arrange for his name to be included in the list. The local obstetric committee normally consists of the consultant obstetrician selected by the Local Medical Committee in consultation with the Regional Hospital Board, a medical officer of health, and two general practitioners nominated by the Local Medical Committee as being experienced in obstetrics. Variations in this constitution appear in different places, and the lists are reviewed by the local obstetric committees from time to time. The practitioner (general practitioner obstetrician) included in the obstetric list is responsible for maternity medical services, but the patient's doctor, if different, remains responsible for her general care, e.g., he would be responsible for dealing with an intercurrent illness during pregnancy. On the advice of the Central Health Services Council, it was suggested in 1953 that future applicants for admission to the obstetric list should be expected to have held six months' resident appointment in an obstetric unit, or be recommended to seek equivalent experience in an obstetric unit, which should include within a period of six months, not less than twenty normal deliveries; attendance at not less than ten abnormal confinements; and attendance at not less than ten antenatal and two post-natal clinics. It was never suggested that the criteria should be applied retrospectively to those already on the list, but they have not, it is understood, been uniformly or rigidly applied in all areas, so that in different areas doctors have been admitted to the list on differing qualifications.

72. In Scotland, the general practitioner providing maternity medical services is paid a fee of seven guineas for each completed case. In the few cases where a general practitioner who has not indicated his willingness to provide maternity medical services does in fact provide them for his own patient, he is paid a fee of five guineas. Any system of admission to a list which lacks rigid criteria and has to depend on selection by a professional body may present difficulties in application, leading to the existence of too many exceptions. This, we gather, is what has tended to happen in England and Wales and, indeed, it is interesting to note that the number of practitioners in Scotland who though they have

indicated their willingness to provide maternity medical services in fact did no maternity work represents some 21 per cent of the whole, a proportion not unlike the 25 per cent of practitioners in England and Wales who are not on the obstetric list.

73. We came to the conclusion, therefore, that if there were a case for the introduction of the obstetric list in Scotland, we should prefer to see it introduced in the shape of a defined initial qualification, coupled with a requirement to undertake refresher courses at intervals of not more than five years. Practitioners already included in the list of those undertaking maternity medical services would be included in the new obstetric list, but would be removed from it if they did not undertake a refresher course, before the expiration of five years from the institution of the obstetric list. Such an arrangement would be consonant with the view of the professional subcommittee that obstetrics must be regarded as a special skill, which can be undertaken only by doctors who have pre- or post-registration training in this specialty. It seems to us that it cannot simultaneously be held to be consonant with the view that obstetrics can be regarded as within the competence of the ordinary general practitioner. If we are right in this, the logical consequence would be that the only general practitioner maternity medical service provided under the National Health Service would be that given by general practitioner obstetricians, for which they would be separately paid.

74. As to the standard to be adopted for admission to the list, six months' resident experience in an obstetric unit should be the basic qualification. The possession of the D.(Obst.)R.C.O.G. would clearly be a valuable additional qualification. As to practicability, the system we have outlined would operate without the intervention of local obstetric committees, thus making unnecessary a selection committee to decide which practitioners should be on the list. There would be adequate warning to enable general practitioners at present providing maternity medical services to obtain the necessary refresher courses and the new entrants would of course require the prescribed qualifications on admission. It has been suggested to us that it might be difficult to arrange the refresher courses, but we should not expect these difficulties to be insuperable. The refresher courses need not all be of uniform length but should be of a uniform standard and should include facilities for bedside instruction. The provision of locums to allow general practitioners to attend these courses should follow the lines of the present post-graduate courses. As for the initial six months' residence, the numbers of available appointments suggest that it should be possible to find such posts for practitioners who wish to qualify themselves. The whole question of fitting-in appointments for six months and of refresher courses would need very careful consideration by the medical schools, who, in our opinion, should be responsible for organising this post-graduate training. We should hope that a consideration of the suggestions we have made would help to encourage new graduates to decide at a sufficiently early point of time, whether they wish to qualify themselves for eventual admission to the obstetric list. Those bodies who opposed the introduction of an obstetric list did so mainly on the ground that " in order to be a good family doctor, each general practitioner should undertake obstetrics for every one of his patients who asks him to ". We have much sympathy with this point of view, and we see our proposal as, in effect, a recommendation that future general practitioners should all be equipped to perform this service. The object of both initial qualification and of the refresher courses is to bring the practitioners into active touch with recent developments in obstetrics, with new methods and with new techniques from time to time. *We recommend, therefore, that a list of general practitioner obstetricians should be introduced in Scotland. The condition of entry for practitioners not undertaking maternity medical services at the time of the introduction of the list*

would be an initial qualification of six months' resident experience in an obstetric unit and the condition of retention would be a requirement to undertake refresher courses at intervals of not more than five years. Practitioners already undertaking maternity medical services at the time of the introduction of the list would be included automatically and all would be subject to removal if they did not undertake a refresher course, officially recognised as qualifying for the purpose, at intervals of not more than five years. (Recommendation 2).

75. We think also that the terms of service should be amended to include, as a specific requirement to be fulfilled if the full payment is to be made, the attendance of the general practitioner obstetrician at some time during labour. While we think it would be most desirable that the general practitioner obstetrician should be in attendance on the woman during delivery of the child and the placenta, we recognise that this may not always be possible in the exigencies of general practice. Accordingly, we do not propose any additional payment for attendance at delivery, contenting ourselves with recommending that attendance during labour should be a necessary condition of payment of the whole fee. This would not alter the present arrangement as regards emergency admissions to hospital during labour.

We recommend, then, that a general practitioner obstetrician undertaking responsibility for the confinement, whether at home or in a general practitioner bed in hospital, should visit during labour and, if possible, be present at the delivery: and the fee to be paid should have regard to this. (Recommendation 3).

76. We have not thought it to be necessary to consider in detail how our recommendations could be carried into practice, so long as we were satisfied that there were no insuperable difficulties in execution. In that a special standard of skill is to be required, that more antenatal work should be undertaken and that attendance during labour would be required, we think that there would be room for a re-examination of the fee to be paid to the general practitioner obstetricians. Another point which has been raised is whether, given an obstetric list in Scotland, it would be logical to continue to regard local health authorities as responsible for the payment of fees of doctors called in by midwives. Their responsibility at present stems from their statutory functions under the Midwives Acts and it might be that legislation would be required to effect a change. In fact there were only 488 such payments made in 1957, this representing 1.7 per cent. of the total of 29,249 domiciliary confinements. These cases, of course, are to be related to the " midwife alone " cases, and if the mother makes her arrangements with both doctor and midwife in future, the likelihood of its being necessary for the midwife to call in a doctor other than the doctor engaged should be even further reduced. The problem in Scotland is small, but we think it would be desirable that there should continue to be uniformity in the method of payment adopted in Scotland with that finally decided upon in England and Wales.

77. The Midwife's Choice. We mentioned in paragraph 64 that we looked for a further decrease in the number of domiciliary confinements in which a midwife alone was engaged. It is to be noted that, under the rules of the Central Midwives Board for Scotland, the midwife's function is regarded as capable of division into two capacities, namely, that in which she is " personally responsible for her patients during pregnancy, labour and the lying-in period ", and those in which she is " acting under the direction of a doctor, who is in charge of the patient, is sent for on the onset of labour and is responsible throughout the labour and lying-in period ". She is not, in her second capacity, regarded merely as a maternity nurse and the relevant rule (Rule D.1) has the following addition which we find especially apt:—" In either of these capacities she is a member of an organised service for the care of the child-bearing woman, and is required to co-operate loyally with other members of the service ". The rule adds the

following footnote which is also very relevant:—" This service comprises midwife, medical practitioner, obstetrical specialist, ambulance service, hospital officers, local supervising authority (M.O.H.), health visitor, supervisor of midwives, ante- and post-natal clinics, etc.". It is in consonance with this that the evidence from the Central Midwives Board for Scotland should specifically state that " the mother should make early contact with her family doctor, who should make provision for the attendance of the midwife. The doctor and midwife between them will make arrangements for the mother's antenatal supervision ". In view of this, and in view of the other evidence to which we have referred in paragraph 20 of our summary of evidence, *we recommend that local health authorities should instruct midwives directly or indirectly employed by them to urge women seeking to engage their services to make arrangements with their general practitioners: and that the midwife should report to the local health authority in any case of difficulty.* (Recommendation 4). The term " their general practitioners " is to be interpreted in the light of what is said above as to the doctor's choice.

78. THE HOSPITAL'S CHOICE. It is probable that one of the main reasons why women may seek to go direct to hospital clinics is because they consider that they are thereby more likely to secure admission to a hospital bed. The choice of place of confinement is perhaps the central question, especially in those areas where there is shortage of accommodation. Apart from medical considerations, all the family circumstances must be taken into account.

79. Some witnesses have suggested that apart from medical and social circumstances hospital accommodation should be available for every woman who desires it. This could not easily be obtained. Since there will always be women who wish to be confined at home, even though ample accommodation is available, the amount required to give adequate choice is something less than would be needed for 100 per cent of the total births (perhaps for 90 per cent). This would clearly be more than the accommodation at present available which, over the whole of Scotland, deals with 70 per cent of the total births, though the distribution is far from even. In the more highly populated areas the proportion of institutional confinements is obtained only by a stay in hospital which we regard as too short, as well as by a degree of overcrowding. Moreover in most areas there is inadequate provision for antenatal admissions.

80. In considering this question we first looked at the present 70 per cent figure. There has been a steady increase in the proportion of hospital confinements from 1949 onwards, and this in spite of the change of the amount of the home confinement grant, as from 16th May, 1955, on the recommendation of the National Insurance Advisory Committee, from £3 to £4 (which has subsequently increased from 3rd February, 1958, to £5). The increase in the grant was designed to equalise, so far as practicable, the cost to the mother of hospital and home confinement, and it might have been expected that it would have reduced the proportion of institutional confinements if, in fact, the previous increases had been to any considerable extent due mainly to the effect on the family budget of the slightly higher cost of domiciliary confinement.

81. We turned next to the distribution of the 70 per cent institutional confinements. A breakdown of the figures for 1957 into local health authority areas showed variations from 96.4 per cent to 50.4 per cent, with 21 areas over 80 per cent, 12 between 70 per cent and 80 per cent, and 22 below 70 per cent, all but six of these last being among the 27 areas in the Western Region, which covers about half the population of Scotland. On a regional basis the same discrepancy between the Western Region and the other four Regions appears perhaps even more clearly. Only the Western Region, at 65.0 per cent, is below the national figure of 70 per cent (Glasgow as low as 57.6 per cent if only

National Health Service accommodation is counted); the three smaller Regions are all above 74 per cent and the South-Eastern Region is 76.3 per cent.

82. As to overcrowding and length of stay in hospital, the average length of stay in obstetric units in the Western Region is again markedly shorter than in the other Regions, and it is obvious that there is very little margin for the occasional emergencies, great or small, which are bound to arise in maternity units, from the closing of an entire unit because of infection, to the closing of one ward while it is painted.

83. As regards antenatal beds, there were many indications that the provision was insufficient. From figures we obtained from the Regional Hospital Boards, it appeared that all the Boards had included antenatal accommodation for statistical purposes, in the obstetric bed complement, though in practice they are not necessarily earmarked for antenatal patients, and such patients may, on occasion, be admitted to gynaecological or general medical wards. The estimation of requirements is bound to be imprecise. We regard it as of great importance that adequate provision should be made. A figure of 8 beds per 1,000 total births was suggested to us, in addition to lying-in beds, and we have made estimates on this basis (see Appendix V); but we think that the resulting figures should be regarded with caution.

84. For our own guidance, we constructed a table—reproduced in Appendix V—which shows the number of hospital beds which would be required for a ten days' stay with the four day intervals which are usually found to be sufficient to cover the ordinary margin for uneven flow of admissions and to allow some antenatal accommodation, to admit 70 per cent, 75 per cent and 80 per cent of the total births respectively in each of the Regions, together with the number of antenatal beds which would be required to provide 8 beds per 1,000 total births. Against these are set the present obstetric bed complements, together with the number of antenatal beds included therein, where this can be stated, and the table then shows the number of additional staffed beds, if any, required to admit 70 per cent, 75 per cent and 80 per cent of the total births, and the additional number of extra beds which would need to be provided if antenatal beds for 8 beds per 1,000 total births were to be added to these three figures.

85. We next considered what other factors in the family circumstances were likely to influence choice of place of confinement, and whether anything in our evidence suggested that they might be expected to show a change in the very clearly marked trend of increase in the proportion of institutional confinements. The professional subcommittee in Chapter IV (paragraph 51) agreed with the consensus of opinion among our witnesses which favoured hospital confinement for (*a*) women with medical or obstetric conditions requiring it; (*b*) primigravidae; (*c*) fourth and subsequent pregnancies; and (*d*) women requiring admission on social grounds. This would require accommodation for not far short of 70 per cent of the total births, with in addition due allowance for antenatal admissions. It might have been expected that the last category would diminish as housing improved, but it has been found that in areas where the housing is good, there is still a continuing demand for hospital beds. The demand arises from a number of reasons, but one very frequently mentioned was the avoidance of upset in the home.

86. Population trends, full employment, and the continuing high proportion of women in employment all mean that there are fewer grandmothers, aunts and other members of the family in a position to come and help at the time of the confinement. It was suggested in several quarters that women hesitated to make use of the domestic help services which are now provided by all the local health authorities in Scotland, because of the allegedly high charges made, and that some reduction for maternity cases might be considered, since this

might help to encourage a new trend towards domiciliary confinement. (The suggestion was a uniform reduction, as distinct from the present power to remit the whole or part of the charges where circumstances warrant this). In view of the lack of impact of the increase of the home confinement grant, we hesitated to accept this last part of the argument, and indeed we could not see how a reduction in charges could be justified in respect of a home help needed for domiciliary confinement, which is, normally a foreseeable event for which preparation can be made, without also providing for a reduction in respect of a home help needed for other, less predictable, emergencies. Moreover the home helps are equally needed and available to deal with the household from which the mother has gone to hospital, and where no one else is there to run the house in her stead. In fact, it seemed to us that this was not a factor in choice of place of confinement, but applied either to home or hospital confinements. Indeed it might almost be held to apply in reverse, for while a husband might look after himself, and perhaps one or two children, during the time his wife was in hospital, he might not be able to cope with the extra work which would be involved in looking after his wife while she was being confined at home.

87. We were reminded that there was an element of fashion in the present popularity of hospital confinement and we had this in mind when we looked at the third factor which needs to be taken into account, the cost to public authorities of the provision of domiciliary and hospital confinement. It seemed to us that if it could be clearly shown that the public cost of a domiciliary confinement, when compared with the cost of a hospital confinement, was markedly less, it was at least our duty to make the facts known. As might perhaps have been expected, however, it is not easy to make a fair comparison. The results of our attempt are embodied in Appendices VI and VII. They show that there are wide variations in the hospital costs, which can mostly be ascribed either to irregular occupancy or exceptional staffing. It is interesting that there is so little difference, comparatively, between the cost of a domiciliary confinement in areas in which there was a high, and areas in which there was a low proportion of domiciliary births. The probable reason is that the basic figures for the cost of a domiciliary confinement, which were taken from Rating Review for 1957 of the Institute of Municipal Treasurers and Accountants (Inc.) (Scottish Branch) are a highly complex construction, based on an apportionment of the time devoted to midwifery of combined district nurse-midwives, who may sometimes also do health visiting, which may not be on a strictly comparable basis in the different areas, in spite of efforts to secure reasonable comparability.

88. From an assessment of these factors, we came to the conclusion that we should recommend that *Regional Hospital Boards should re-assess as a matter of urgency their need for maternity hospital accommodation to provide for antenatal admissions of not less than* 8 *beds per* 1,000 *births per year together with lying-in beds for* 70 *to* 75 *per cent of the total births.* (Recommendation 5).

In making this recommendation, we have in mind particularly the difficulties of the Western Region, where the provision of extra antenatal and lying-in beds is urgently required. This is in addition to replacements, becoming increasingly necessary. The provision of more ample accommodation would reduce overcrowding and the strain which it implies for the nursing and medical staff, and should be conducive to better obstetric practice, and to reducing what risk of infection there may be. While we have not felt that it was incumbent on us to make calculations of capital cost, or of running costs, we could not fail to be impressed by the fact that the minimum capital cost per bed seemed likely to be of the order of £5,000, and we should indeed like to make clear two things. Firstly, that we should hope that most of any additional maternity hospital accommodation which may prove to be necessary, after the additions already in course of construction are opened, would be in the form of accommodation in

general practitioner units, which may not he quite so expensive as the more highly specialised accommodation. Secondly, that it may he possible that hospital accommodation found to be surplus to requirements for other purposes will prove suitable for adaptation. We shall consider the administration of general practitioner units and their relation to the specialist services in further detail later.

89. In effect, our recommendation on the provision of maternity hospital accommodation relates mainly and most urgently to the Western Region and particularly to the area of Glasgow itself and its surroundings. It is there that the demand is so much greater than the supply, a position which should be remedied as quickly as possible; hut until the supply can be increased, it is of the utmost importance that everything should be done to ensure that the best use is made of the accommodation which is available.

90. Here, the first requisite is the restriction of the hospital's hookings to patients referred by their general practitioner, and the elimination, so far as possible, of the provisional hookings hy the hospital which seem to have been a continued source of difficulty. Every maternity hospital is faced with very similar prohlems. Births do not spread themselves conveniently over the year, even with the large numbers with which a big obstetric unit is concerned; there are always obstetric emergencies to be allowed for; there are varying proportions of antenatal admissions for varying lengths of time, some of them needing to be accommodated among the lying-in beds; and since any of the individual applicants may require admission earlier or later than their expected date of confinement, it must be agreed that the admission problems of a busy ohstetric unit are more than ordinarily complicated.

91. Even though as a general rule all hookings and ordinary admissions were made on reference from a general practitioner, however, there will remain a problem of selection so long as the accommodation is insufficient. It is where admission is sought mainly on social grounds, or mainly at the mother's own wish without circumstances which would readily justify priority on either medical or social grounds, that difficulties have arisen. We think that so long as there is shortage of available accommodation, the hospital should seek the confirmation of social needs from the medical officer of health, who is in the best position to assess the priorities in this respect. If he finds himself unable to support the recommendation, he should discuss the position with the general practitioner referring the patient, hefore reporting back to the hospital. If, after this, it is clear that no firm booking can be made, the general practitioner and the medical officer of health should ensure that adequate arrangements are made for a domiciliary confinement, including the booking of a midwife. It is understandable that hospitals and hospital clinics should form very close honds with women who have been confined before at the hospital and desire to return there, but the circumstances of each confinement may vary. While we have accepted the general, though not universal, view that first births should preferably be in hospital, there is perhaps least justification for the admission to hospital of a woman with reasonable home conditions for her second confinement, unless medical or obstetric complications are anticipated. The point of special importance is, however, that, in our view, at all costs, and even at the cost of leaving beds empty because the margin has been over-estimated, a last minute decision on a domiciliary confinement ought to be avoided. *We recommend, therefore, that Regional Hospital Boards review the systems of admission to obstetric units to ensure that the best use is made of the available accommodation and that the admission system in force will secure (subject to quite unforeseen emergency) that bookings are honoured.* (Recommendation 6).

92. The Local Health Authority's Choice. We gave some thought to the place of the local health authority clinic in the maternity services when we were

considering the mother's choice, and we envisaged the clinic as providing services either in substitution for, or in addition to, the services available from general practitioner and midwife, or from the hospital, according to whether a woman is to be confined at home or in hospital. It is not infrequently in connection with the use of local health authority clinics that questions of co-ordination and confusion arise, and it may be useful to quote in full the comment of the Guillebaud Committee on this point in paragraph 638 of their Report in which they noted the fall in attendances at these clinics with the introduction of the National Health Service, and deprecated the loss of valuable facilities for the teaching of mothercraft and for other forms of health education which this implied. They said:

> " We do not consider it necessarily a bad thing that the organisation of the maternity services should have shown divergent trends in different areas, since the varied experience gained will be of great value in considering what should be the right lines of development in future; but we do think the stage has been reached when an authoritative enquiry should be set on foot to evaluate the work now being done and to arrive at some conclusions as to the most efficient forms of provision.
>
> While it is not for us to prejudge the work of any committee that might be appointed to review the maternity services, we would suggest that the following principles might be borne in mind:
>
> (i) Preventive medicine begins with the expectant mother and her unborn child. It is vitally important that all expectant mothers should receive advice on mothercraft, diet, care of the unborn child, etc., and that the responsibility for providing this advice should be clearly known to the authorities and officers concerned. The appropriate measures taken at this time of the mother's life will have a beneficial effect on the health (including the dental health) of future generations.
>
> (ii) As the numbers of women attending local authority antenatal clinics have fallen since the Appointed Day, it may be that many women are now failing to receive the instruction they need in preventive health, and steps should be taken to make good this omission. If, for example, a woman has booked a doctor to provide maternity medical services, the doctor should be responsible either for providing *the whole* of the necessary instruction himself or (and this is most likely to apply in the majority of cases) advising the woman to attend the local authority clinic. The same obligation should lie on the hospital which has booked a maternity case, i.e., either to provide *the whole* of the appropriate instruction at the hospital or to arrange for its provision through the local authority clinics. As we understand it, there are at present only a few hospitals which provide training in mothercraft as well as medical antenatal and post-natal treatment.
>
> (iii) The role of the local authority clinic may have changed in recent years, but it is just as important now under its new guise as it was under the old; and we should consider it a most retrograde step if the organisation of the maternity services under the National Health Service were to discourage mothers from attending the clinics, without at least providing equivalent services by some other means."

It was indeed the recommendation in the next paragraph of the Guillebaud Report which led to the appointment of our Committee at the same time as the Cranbrook Committee in England and Wales.

93. Much of our evidence bore out the suggestion in the paragraph we have quoted. We noted, in paragraph 36 of our summary of evidence, that we were left in no doubt that the maternity service would be incomplete if it did not also provide for the instruction of mothers, both individually and in groups, in parentcraft and health education. These subjects were generally recognised as pre-eminently the province of the local health authority. Both the Scottish Association of Executive Councils and the Scottish Council of the British Medical Association wished to see this kind of instruction continued and

developed, though they might not go so far as to agree with the suggestion of the Scottish Branch of the Society of Medical Officers of Health that general practitioners should be required to refer their patients to clinics for such instruction. We should, nevertheless, expect that a general practitioner obstetrician would make himself responsible for referring his patient to a clinic, if he were not prepared to undertake such instruction himself.

94. As regards mothers booked for hospital confinement, there is some provision for mothercraft teaching at most of the larger hospitals, but we were told that this needed to be developed in some areas and we gathered from some sources that there was scope for closer working with the local health authorities who will also be co-operating in the follow-up of any booked patients who may fail to attend after one or two visits. It was suggested to us that mothercraft instruction in some hospitals tended to be too little geared to the home conditions to which the mother would return. A suggestion was made that local health authority medical officers and/or health visitors might with advantage be given access to hospital clinics for the purpose of giving this instruction.

95. It seems to us that both the Guillebaud Report and the witnesses we have cited tend to regard instruction in mothercraft and health education as a distinct function separable from medical supervision and treatment. But much of the instruction must lose its point if it is not brought in to reinforce and illuminate the medical advice for herself and her child which is a mother's first concern. If our suggestion for an intensification of antenatal care is adopted, the mother will need to make more frequent visits to her general practitioner or to the hospital and she will need to be convinced, by the general attitude of her doctor and midwife, if she is to be encouraged to make additional visits for purposes of instruction. She is less likely to make them, even if she is convinced, if they are to a different place or to see different people. It seems to us, therefore, that it is most desirable that general practitioner obstetricians should be brought into the local health authority clinics as far as possible and, in addition, that local health authority staffs should be afforded access to hospital clinics, and given adequate accommodation there. Further, hospital obstetricians should be made available to attend local health authority clinics where circumstances warrant, so that mothers booked for hospital confinement and living at a distance, could, during the period between initial and final medical examinations attend at the more accessible local health authority clinics for intermediate examination. They could then at the same time avail themselves of the opportunities afforded at the clinics for mothercraft or parentcraft instruction and general health education. The presence of the hospital obstetrician and the general practitioner obstetrician in the one clinic would also facilitate greatly the consultation of the former by the latter with regard to domiciliary cases. All this means, however, that the general practitioners and the consultant obstetricians must be convinced of the value of this work, must know the lines on which instruction is likely to be given at the clinics with which they are associated, and must be prepared to show mothers, by their own attitude, the value they place on activities of this kind.

96. Such arrangements would lead ultimately to the disappearance of the local authority maternity and child welfare medical officers as we know them today. They have played a notable part in the care of expectant mothers and secured for them routine medical supervision which might not otherwise have been available. But with the availability of the general practitioner obstetrician for medical antenatal care, the role of the maternity and child welfare medical officer becomes restricted. Our emphasis on the continuity of medical care throughout pregnancy, labour and lying-in places responsibility for the antenatal care, on the doctor who takes ultimate responsibility for the confinement. There is need for the closest co-operation, in the interests of the mother between

practitioners, midwives and health visitors. The use of the clinic by the whole team should make it possible for the practitioner to secure for his patients all the resources of both local health authority and specialist facilities as may be necessary. We should not attempt to lay down any pattern for future development, since different practices may be found desirable in different areas and it is obviously desirable that there should be freedom for experiment. We welcome the introduction of appointments systems and would urge the extension of the system at other clinics, whether local authority or hospital clinics, and these appointments should be, so far as possible, arranged to enable the mother visiting the clinic for purposes of medical examination also to take part in group instruction and other activities.

97. There must be many possible variations in the pattern of co-operation, which will depend on the circumstances of the practitioners and the clinic facilities available. What seems to us to be essential is that the local health authority clinic should cease to be regarded (if in any area it has been so regarded) as in any sense a rival establishment to the clinics which some general practitioners have held within their own practices, or to the clinics of obstetric units in hospitals. They would become, as we have suggested, the meeting place for all three branches of the Service. Moreover, as our witnesses and the Guillebaud Report suggest, local health authorities and their officers who are rightly to be regarded as specialists in preventive medicine and in health education, will be prepared to make their facilities available outside their clinics, by lending the services of their staff to hospital clinics, or to practitioners wishing to run antenatal clinics within their own practices. We envisage that not only should local health authority staff be available for these duties at antenatal clinics but that general medical practitioners and obstetricians will make full use of their services for the follow-up of women who fail to keep their appointments for antenatal examinations.

98. From 1948 onwards, local health authorities have had a duty, under section 22 of the National Health Service (Scotland) Act, 1947, to provide for the dental care of mothers and young children. This obligation on local health authorities was intended to secure for mothers and young children the priority which could not be secured to them under the General Dental Service because of the shortage of dentists. It was anticipated that use would be made of the staff of the School Dental Service for the most part, directly by the local health authorities who were also education authorities, and by arrangement with the education authorities by those who were not, though it might sometimes be necessary to employ separate whole-time dentists for the provision of dental services to mothers and young children. Unfortunately, the School Dental Services themselves were short staffed, and in the early days of the National Health Service, their ranks were still further depleted by the resignations of dentists who saw better prospects in the General Dental Service. The introduction of charges into the General Dental Service helped to restore the balance, but, while the total number of dentists employed by local health and education authorities now considerably exceeds the total in 1948, it still falls short of estimated requirements and there is still difficulty in recruiting additional staffs. It is open to a local health authority to make arrangements with dentists who are in the General Dental Service, provided they are prepared to make payment not only for what would be the mother's share of the charges for dentures but also for the share which would be met by the Executive Council.

99. The British Dental Association, as we noted in paragraph 38 of our summary of evidence, made powerful representations to the effect that it was desirable for all services under the General Dental Service to be free to expectant mothers. We have some sympathy with the suggestion, since we know that many local health authorities are obliged to make their provision for at least the supply

of dentures to expectant and nursing mothers by making arrangements with dentists in the General Dental Service. We feel that there should be no difficulty in arranging that expectant mothers should receive both dentures and treatment free, from whatever source they obtain them.

100. We share the view of the British Dental Association, and of many other witnesses, on the importance of dental care and dental education and we are clear that more should be done to encourage mothers to use the facilities which are available, as well as to improve those facilities. Here the use of local health authority clinics can be of great value, for if dental facilities can be made available on the spot, mothers are more likely to use them, and this is, we understand, borne out by the experience of authorities who have recently provided new clinics with dental facilities. Moreover, even if it is not possible to undertake much conservative dentistry for the mothers themselves, they can more readily be brought to see the advantages of the care of their children's teeth, and the importance of periodic examination and early treatment, if they have ready access to these facilities.

101. Another reason for reference to clinics, or for encouraging the use of clinics by the patients of general practitioner obstetricians, is the fact that they act as distribution centres for welfare foods which include vitamin supplements. Indeed, one of the principal reasons for handing over the work of distribution to the local health authorities, when local food offices were closed, was to enable this work to be closely associated with the authorities' services for the care of mothers and young children.

102. To sum up, *we recommend that the facilities of local health authority clinic premises and the services of their staffs should be utilised both by the hospital staffs and by general practitioner obstetricians, who would be enabled to take advantage for their patients of all the facilities available in these clinics, including those for group teaching of mothercraft or parentcraft and health education, as well as priority dental services and the provision of welfare foods (including vitamin supplements).* (Recommendation 7).

General Problems of Securing, within the Framework of the Service, the Range of Provisions which should be Available

103. The recommendations we have made should, if they can be put into operation successfully, go far to ensure the provision, within the framework of the Service of comprehensive facilities for medical care and supervision, together with health education and guidance. We should like to consider in a little more detail some topics which have arisen in the course of our discussion, before we turn to the final question of whether we should recommend any special measures, in addition to those already taken in many areas, for securing co-ordination and smooth working between the various parts of the maternity services.

104. The Medical Staffing of General Practitioner Units. There are numbers of hospitals of the cottage hospital type, particularly in the North of Scotland, in which general practitioners accept full responsibility for the confinements. The general practitioners are in contact with the Executive Councils and receive payment for maternity medical services, as they would do if they had been responsible for a domiciliary confinement, and they call on consultant advice as they think necessary. The midwife is on the staff of the hospital (in the smallest hospitals she may be the matron) and the numbers of practitioners and patients are not so great as to raise questions of difficulty over, say, different techniques adopted by different doctors for patients in the same ward. Efficient working depends on harmonious relationships between consultant obstetricians and general practitioners using such units.

105. Other general practitioner units are attached to obstetric hospitals, being situated either in the same hospital, or sufficiently near it, so as to enable the consultant obstetrician to be in close touch with the unit. Obviously there will require to be general agreement between the general practitioners, the consultant obstetricians and the nursing staff, as to obstetric techniques. In fact, in both types of unit, the Regional Hospital Board must be responsible for administration and arrange for consultant cover and advice, to ensure adequate technical standards, and to deal with length of stay in hospital and other cognate problems.

106. The introduction of an obstetric list on lines such as we have recommended above, must, of course, affect both types of unit, for if only one type of maternity medical service is to be recognised in the National Health Service, only general practitioner obstetricians could be allowed to use either type of unit. We should hope, indeed, that the establishment of the list would encourage and foster close relationship with the consultant obstetricians working in the area.

107. If the general practitioner obstetrician takes his place as a member of the local obstetric team, most of the difficulties which may have arisen in the past ought to be overcome. He would discuss with his patient the appropriate place for her confinement, consulting, as necessary, the midwife if a domiciliary confinement is the wish of the patient. If the midwife felt doubtful about the suitability of the patient's home, and were unable to convince the general practitioner obstetrician that it would be desirable to persuade the woman to go to hospital, it would then become her duty as a midwife to notify the local supervising authority, but we should hope that the closer working of all concerned in the maternity services which is gradually being established, would make this an extremely rare occurrence.

108. THE EFFECT OF A HIGH PROPORTION OF HOSPITAL CONFINEMENTS ON THE STAFFING OF THE DOMICILIARY MIDWIFERY SERVICE. Just as there are now fewer practitioners undertaking twenty or more confinements a year than there were twenty years ago, so there is increasingly less work for domiciliary midwives. The proportion of domiciliary confinements varies from area to area, but there are areas in which midwives, who are often also the district nurses, undertake only a few cases a year, so that the bulk of their maternity work may consist of antenatal and post-natal visits to mothers who are confined in hospital.

109. The problems raised already are, however, sufficiently serious to merit attention. They go beyond our immediate terms of reference, and they should be the subject of a separate review. The trend towards institutional confinement has introduced changes in the field of domiciliary midwifery. Moreover, the reduction in the number of home confinements has meant a smaller number of midwives each undertaking duties over a wider area. The midwife, particularly in rural areas, is often required to provide routine antenatal supervision of women booked for hospital confinement and to resume care on their early discharge from hospital. She is thus deprived of practical midwifery. Much will depend on the relationship established between the general practitioner obstetricians and the midwives, but if there is not a sufficiency of interesting work for domiciliary midwives it will become increasingly difficult to recruit them and the prospects of recruitment of midwives even for maternity units is not so encouraging as to leave any room for increasing the difficulties. Suggestions were made to us that trained nurses on taking up training as midwives suffered financially, and that this was a factor in poor recruitment. Another suggestion was that all large obstetric units in general hospitals should have an independent matron. These were points which we felt were outwith our remit, but we do realise that there is a very large problem in the whole field of recruitment, training and work of midwives, which needs to be looked at again now

that some ten years has passed since the *Report of the Working Party on Midwives.

110. LENGTH OF STAY IN HOSPITAL. The general opinion among our witnesses was, as we noted in paragraph 28 of our summary of evidence, in favour of a ten day stay. While this is the average length of stay in obstetric units in Scotland generally, that average is, of course, made up of much longer and much shorter stays. We are aware of the suggestion made to us by the British Paediatric Association that it would be useful for a pilot experiment in very early discharge from hospital to be undertaken, but until the results of a scientific investigation become known there are certain factors which must be given due weight in deciding present policy.

It is almost universally agreed that discharge before the tenth day makes establishment of breast feeding more difficult. It also leaves the mother on reaching home considerably less experienced in the handling and general management of the baby, and it must be remembered that a considerable proportion of the mothers confined in hospital are primiparae. On her return home also she is expected, only too often, to resume her full household responsibilities at once although she needs a period for recuperation and rest after her confinement. Whatever the length of stay, it is important that adequate notice of the discharge of the mother from hospital should be given both to the medical officer of health, and to the general practitioner, if he is not (as general practitioner obstetrician) already in charge of the case. This should enable the local health authority to arrange for suitable follow-up.

Under the Rules of the Central Midwives' Board, supervision must be given for a period of not less than fourteen days in the puerperium. Early discharge from hospital may mean that after reaching home the domiciliary midwife takes over for the few remaining days of this period and then hands over to the health visitor. This frequent change of advisers is bad. Indeed, if a mother is considered to be fit for discharge home on the tenth day it could be argued that the normal puerperium should be officially recognised in the Central Midwives' Board Rules as of ten days duration, thus eliminating the domiciliary midwife as one link in this chain—a change which would be welcomed. For these reasons we feel that discharge before the tenth day should meantime be regarded as undesirable, and in fact where beds and staffing permit, retention till the fourteenth day has much to commend it. We have, in Chapter IV, paragraph 48, accepted the need for the doctor to continue in attendance for fourteen days.

111. PAEDIATRIC SUPERVISION OF THE NEWBORN. The British Paediatric Association firmly believe that closer liaison between obstetricians and paediatricians, both antenatally and during lying-in, would favour a further reduction in morbidity and mortality in the newborn, since many of the problems of perinatal mortality are not clearly divisible into those of stillbirth and those of neo-natal death. A classification of the causes of neo-natal deaths on the lines of those of stillbirths would be most helpful. Prematurity and haemolytic disease of the newborn are notable examples of conditions requiring close co-operation between obstetrician and paediatrician both before and after the birth of the baby. We agree with the recommendation that a consultant paediatrician should be appointed to all maternity units with sufficient sessions to cover routine visits in addition to emergency calls, for it is important that the paediatrician should share with the obstetrician clinical and administrative responsibility for the routine care of babies—notably premature babies—and should not simply be available for the treatment of established illness. We believe that this pattern, which has evolved in the principal teaching maternity hospitals where it is now functioning successfully, should be adopted in all maternity units. We also endorse the recommendation of the Joint Standing

*Report of the Working Party on Midwives, 1949. H.M.S.O.

Committee on Prematurity of tbe Royal College of Obstetricians and Gynaecologists and the British Paediatric Association tbat a suitably equipped and staffed premature baby unit sbould be provided in eacb area, since a generally high standard of care of premature infants must make a major contribution towards a further reduction of the neo-natal mortality rate.

112. Laboratory Facilities. Several of our witnesses told us tbat existing laboratory facilities were not always adequate, or might not be readily available in emergency. We understand tbat as a result of the recent Report of the Dunlop Committee on Laboratory Services, a review of the services in each Region is being undertaken by co-ordinating committees on lines recommended in the Report. We would draw tbeir attention to the special needs of the maternity services in their review.

113. Family Planning. We endorse the suggestion that it is desirable that facilities for advice on family planning should be available. We know that some local health authorities and Regional Hospital Boards provide them, and otbers bave made arrangements with voluntary associations who help in this work. We understand that, at present, while advice on tbese matters may be obtained from general practitioners, they are not able to prescribe under tbe National Health Service all tbe appliances which may be required. It seems to us that the possibility of removing this anomaly sbould be examined.

The Co-ordination of the Parts of the Maternity Services

114. The aim of all our recommendations has been to secure that the mother, tbe midwife, the general practitioner, the local health authority clinic and the hospital staffs should all regard the maternity services as a single service, designed to afford the mother all the facilities necessary for her medical care and supervision, as well as for instruction in parentcraft and general healtb guidance. We think this can best be secured through good relationships between tbe people concerned with the day-to-day running of the various parts of tbe service. We know that in many areas this has in fact been achieved and we would hesitate to make any recommendations which would disturb existing arrangements whicb bave already brought about a substantial measure of co-operation and co-ordination. In other areas, however, it is clear that there is room for bringing into closer harmony tbe activities of those who are, in their respective spberes, making their contribution to the maternity service.

115. In our view, the desire to co-operate is not enough by itself: we came to the conclusion that some central leadership migbt be needed, and that we could usefully recommend machinery which would help to initiate co-ordination, wbere necessary, and, wbat is of equal importance, to help to maintain it. We are convinced that it would be undesirable to set up any superior body, bowever composed, above tbe three authorities, witb executive power to direct and control their activities and to supervise their administration. What we think is required is to ensure that there is some meeting point at whicb information can and will be exchanged on the extent of the activities of each autbority, where the needs of the service can be reviewed, wbere problems and difficulties of common interest can be discussed, and wbere points of contact between the parts of the service can be examined, with a view to smootber working and better integration. We are most reluctant to suggest any uniform arrangement—sucb as a co-ordinating committee at regional level—for circumstances vary in many areas, and we see no reason wby the opportunity for planning should not be left with those immediately concerned.

116. After most careful consideration, we propose to recommend a structure which we believe would provide the necessary stimulus to initiating and maintaining co-ordination, and at the same time leave the maximum freedom for local enterprise.

(*a*) It seems to us that the first requirement is for the Secretary of State, through the Department of Health, to assume the initiative by requiring each Regional Hospital Board to give special consideration to the maternity services of their region and to inform him, in some detail, of the local arrangements which have heen made for their effective co-ordination. We suggest the Regional Hospital Board as the appropriate body to undertake this duty, chiefly because they deal directly or indirectly with the largest proportion of confinements, but it must be clearly understood that they are hut one partner, and that the local arrangements should be the result of the fullest discussion with the local health authorities and Executive Councils as partners with equal responsibility for the service as a whole. It seems to us, also, equally essential that the Secretary of State should require further progress reports from time to time.

(*b*) In the second place we think it would he desirable that the Secretary of State should have the benefit of the advice of an expert committee (under the aegis of the Scottish Health Services Council) which would be constituted as a standing committee to which could be referred from time to time specific prohlems in the field of obstetrics, and the technical organisation of the maternity service. The maternity service seems to us hoth sufficiently large and sufficiently small to warrant this recommendation. It is large in the diverse ways in which it impinges on the health of the nation; it is small in the sense that its problems are relatively limited though many of them are highly technical. Membership of the committee should he representative of all the disciplines concerned in the maternity service, and one of their first tasks might well be to consider and advise on the progress reports received from the regions.

There are other matters, too, which could usefully be referred to such a central body, such as the question mentioned in Chapter IV of the sort of records which ought to be available, both from the point of view of technical obstetrics, and from the point of view of interchange of necessary information between those concerned with individual mothers.

(*c*) Thirdly, we think that there is great advantage in professional committees at other levels, either covering a whole region, or the parts of a region served hy individual ohstetric units. Professional committees would be composed of persons engaged in the day-to-day working of the service. We helieve that this may be the best way of securing liaison at regional and hospital level, and we would emphasise that there is nothing to prevent such bodies being set up at any time.

We think that Regional Hospital Boards should estahlish such committees now. They may well find them an indispensable part of effective local arrangements for co-ordination, but, as we have indicated ahove, we do not wish to suggest a procedure for universal application which might disturb, or complicate, existing arrangements which are working well.

117. *To sum up, we recommend that the Secretary of State should initiate action to ensure co-ordination by a specific requirement of a report from each Regional Hospital Board setting out the arrangements in operation and the method of maintaining co-operation; that he should have available, for consultation on the reports and on other matters affecting the organisation and content of the maternity service a standing advisory committee under the aegis of the Scottish Health Services Council; and that the reports should contain provision for the establishment of professional committees, at appropriate levels, as part of the local arrangements to ensure the smooth working of the maternity service.* (Recommendation 8).

118. We should not like to end without paying tribute to the work which is being carried out by all the branches concerned in the maternity service. The problems of faulty co-ordination are apt to acquire notoriety. Much less is heard of the many cases in which good co-ordination exists to the great benefit of the mothers of this country.

Chapter VI. Summary of Recommendations contained in Chapter V

119. As it seems to us that much of the confusion in the maternity services is related to the many choices provided and the risk of lack of continuity of medical care, we think that a primary requirement is that one person should be regarded as the co-ordinator. We believe this should be the general medical practitioner. Accordingly we recommend:

1. It should be the responsibility of the general practitioner to provide or secure the provision of all the facilities required by the mother during pregnancy, confinement and lying-in. (Paragraph 67). No problem should rise where the practitioner is himself to be responsible for the confinement, but when he is not, we regard it as essential that he should be informed by anyone else who has accepted the care of the woman (see paragraph 69).

2. A list of general practitioner obstetricians should be introduced in Scotland. The condition of entry for practitioners not undertaking maternity medical services at the time of the introduction of the list would be an initial qualification of six months' resident experience in an obstetric unit and the condition of retention would be a requirement to undertake refresher courses at intervals of not more than five years. Practitioners already undertaking maternity medical services at the time of the introduction of the list would be included automatically and all would be subject to removal if they did not undertake a refresher course, officially recognised as qualifying for the purpose, at intervals of not more than five years. (Paragraph 74).

3. A general practitioner obstetrician undertaking responsibility for the confinement, whether at home or in a general practitioner bed in hospital, should visit during labour and, if possible, be present at the delivery: and the fee to be paid should have regard to this. (Paragraph 75).

4. Local health authorities should instruct midwives directly or indirectly employed by them to urge women seeking to engage their services to make arrangements with their general practitioners: and the midwife should report to the local health authority in any case of difficulty. (Paragraph 77).

5. Regional Hospital Boards should re-assess as a matter of urgency their need for maternity hospital accommodation to provide for antenatal admissions of not less than 8 beds per 1,000 births per year, together with lying-in beds for 70 to 75 per cent of the total births. (Paragraph 88).

6. Regional Hospital Boards should review the systems of admission to obstetric units, to ensure that the best use is made of the available accommodation and that the admission system in force will secure (subject to quite unforeseen emergency) that bookings are honoured. (Paragraph 91).

7. The facilities of local health authority clinic premises and the services of their staffs should be utilised both by the hospital staffs and by general practitioner obstetricians, who would be enabled to take advantage for their patients of all the facilities available in these clinics, including those for group teaching

of mothercraft or parentcraft and health education, as well as priority denta services and the provision of welfare foods (including vitamin supplements). (Paragraph 102).

8. The Secretary of State should initiate action to ensure co-ordination by a specific requirement of a report from each Regional Hospital Board setting out the arrangements in operation and the method of maintaining co-operation; he should have available, for consultation on the reports and on other matters affecting the organisation and content of the maternity service, a standing advisory committee under the aegis of the Scottish Health Services Council; and the reports should contain provision for the establishment of professional committees, at appropriate levels, as part of the local arrangements to ensure the smooth working of the maternity service. (Paragraph 117).

120. We have also made various suggestions for the further consideration of a number of topics, for the attention of the authorities concerned.

GEORGE L. MONTGOMERY
MAY D. BAIRD
JOHN T. BALDWIN
MARY B. CLYNE
MARY S. EWART
MARY FRASER
CHAS. S. GUMLEY
KATE HARROWER
J. L. HENDERSON
A. R. HOWIE
HECTOR R. MACLENNAN
DOUGLAS MILLER
ELSIE RENWICK
JOHN RIDDELL
J. STORRAR
ARCHD. A. TEMPLETON
NORA I. WATTIE

Medical Secy. MABEL E. MITCHELL
Lay Secy. L. C. WATSON

APPENDIX I

A list of Associations, Organisations, etc., who submitted written evidence

ASSOCIATIONS:

Association of Counties of Cities
Association of County Councils in Scotland (including evidence submitted by Dr. S. Harvey, M.B., CH.B., D.P.H., M.R.C.P.(Edinburgh), Medical Officer of Health, Dunbarton County)
Association of Scottish Hospital Matrons
British Dental Association
British Medical Association (Scottish Office)
British Paediatric Association
National Association for Maternal and Child Welfare
National Childbirth Association of Great Britain
Scottish Association of Executive Councils
Scottish Health Visitors' Association

REGIONAL HOSPITAL BOARDS (SCOTLAND):

Eastern
Northern
North-Eastern
South-Eastern
Western

OTHERS:

Central Midwives Board for Scotland
Chartered Society of Physiotherapy
Corporation of City of Glasgow
Department of Health for Scotland
Glasgow Obstetrical and Gynaecological Society
Medical Officer of Health of the Burgh of Paisley
Medical Women's Federation (Scotland)
Queen's Institute of District Nursing (Scottish Branch)
Royal College of Midwives (Scottish Council)
Royal College of Nursing (Scottish Board)
Royal College of Physicians and Royal College of Surgeons of Edinburgh and Edinburgh Obstetrical Society
Royal Faculty of Physicians and Surgeons of Glasgow
Scottish Council of the College of General Practitioners
Scottish Regional Committee, Institute of Almoners (Incorporated)
Scottish Standing Committee of the Royal College of Obstetricians and Gynaecologists
Society of Medical Officers of Health (Scottish Branch)
West of Scotland Federation of Townswomen's Guilds

APPENDIX II

Witnesses Giving Oral Evidence

Association of Counties of Cities

Councillor Mrs. M. A. McAllister (now M.P.) J.P.
Miss A. A. Fulton, M.D., D.P.H.
J. L. Gilloran, Esq., M.B., CH.B., D.P.H.
I. A. G. MacQueen, Esq., M.A., M.D., D.P.H.

Association of County Councils in Scotland

Rev. J. A. Fisher
W. T. Dundas, Esq., B.L.
S. Harvey, Esq., M.B., CH.B., D.P.H., M.R.C.P.E.
E. Neil Reid, Esq., M.A., B.SC., M.B., CH.B., D.P.H.
G. Davie, Esq., O.B.E., B.L., S.S.C. (Secretary)
F. Inglis, Esq. (Assistant Secretary)

Association of Scottish Hospital Matrons

Miss J. P. Ferlie, O.B.E., R.G.N., S.C.M.
Miss B. H. Renton, O.B.E., R.G.N., S.C.M., R.N.T.

British Dental Association

P. G. Capon, Esq., M.D.S., F.D.S.
T. Neil Rose, Esq., L.D.S.
S. R. Bragg, Esq. (Assistant Secretary)

British Medical Association (Scottish Office)

Miss A. A. Fulton, M.D., D.P.H.
M. M. Garrey, Esq., M.B., CH.B., D.P.H., M.R.C.O.G.
W. M. Knox, Esq., M.B., CH.B.
C. J. Swanson, Esq., M.B., CH.B.
E. R. C. Walker, Esq., B.A., M.D., F.R.C.P.E. (Secretary)
J. T. McCutcheon, Esq., M.A., L.R.C.P.E. (Assistant Secretary)

Scottish Association of Executive Councils

J. M. D. Gill, Esq., M.B., CH.B.
G. McIver, Esq.
A. R. Howie, Esq. (Secretary)

Scottish Health Visitors' Association

Miss D. J. Lamont, R.G.N., S.C.M., H.V., H.V. TUTOR'S CERTIFICATE
Miss E. H. Strong, R.O.N., S.C.M., R.F.N., H.V.

Scottish Paediatric Society

Professor J. Craig, M.B., CH.B., F.R.C.P.E.
J. W. Farquhar, Esq., M.B., CH.B., F.R.C.P.E.
J. H. Hutchison, Esq., O.B.E., M.D., F.R.F.P.S.G., F.R.C.P.L. (Hon. Secretary and Treasurer)

REGIONAL HOSPITAL BOARDS (SCOTLAND)

Eastern Regional Hospital Board

Mrs. A. M. Allardice
C. Bainbridge, Esq., O.B.E., M.B., B.S., B.HY., D.P.H. (Senior Administrative Medical Officer)

Northern Regional Hospital Board

D. C. Wilson, Esq., V.D., M.D., F.R.C.P.E.
A. M. Fraser, Esq., M.D., F.R.C.P.E., D.P.H. (Secretary and Administrative Medical Officer)

North-Eastern Regional Hospital Board

Professor D. Baird, B.SC., M.D., F.R.C.O.G., D.P.H.
Mrs. J. Wolrige Gordon
J. C. Knox, Esq., C.B.E., B.SC., M.B., CH.B., D.P.H. (Senior Administrative Medical Officer)

South-Eastern Regional Hospital Board

Miss J. P. Ferlie, O.B.E., R.G.N., S.C.M.
J. C. G. Mercer, Esq., M.B., CH.B., D.C.H.
H. A. Raeburn, Esq., M.D., F.R.C.P.E., D.P.H. (Senior Administrative Medical Officer)

Western Regional Hospital Board

D. L. Kerr, Esq., O.B.E., T.D., M.B., CH.B.
R. F. Macdonald, Esq., M.D., D.P.H. (Assistant Senior Medical Officer)

Central Midwives Board for Scotland

Miss J. P. Ferlie, O.B.E., R.G.N., S.C.M.
W. F. T. Haultain, Esq., O.B.E., M.C., B.A., M.B., B.CH., F.R.C.P.E., F.R.C.S.E., F.R.C.O.G.
Professor R. A. Lennie, T.D., M.D., LL.D., F.R.F.P.S.G., F.R.C.O.G.

Corporation of City of Glasgow

Bailie J. Bias
Councillor Mrs. M. A. McAlister (now M.P.) J.P.
W. A. Horne, Esq., M.D., D.P.H.
R. D. Bryson, Esq., B.L.

Department of Health for Scotland

Miss C. A. Douglas, O.B.E., M.D., F.R.C.O.G., D.P.H.
P. L. McKinlay, Esq., M.D., D.P.H., F.R.S.E., F.S.S.

Glasgow Obstetrical and Gynaecological Society

Professor D. Fyfe Anderson, M.D., F.R.P.P.S.G., F.R.C.O.G.
W. C. Armstrong, Esq., T.D., M.B., CH.B., F.R.F.P.S.G., F.R.C.O.G.
R. A. Tennent, Esq., M.B.E., M.B., CH.B., F.R.F.P.S.G., F.R.C.O.G. (Secretary)

Medical Officer of Health of the Burgh of Paisley

T. Y. Bennie, Esq., M.B., CH.B., D.P.H.

Medical Women's Federation (Scotland)

Miss M. Esslemont, C.B.E., B.SC., M.A., LL.D., M.B., CH.B., D.P.H.
Miss M. D. Giles, M.D., D.C.H.
Miss S. J. Paterson, M.A., M.D., F.R.C.S.E., F.R.C.O.G.

Queen's Institute of District Nursing (Scottish Branch)

Miss B. T. Gilmour, R.G.N., S.C.M., Q.N., H.V.
Miss E. W. Himsworth, R.G.N., S.C.M., Q.N., H.V.
Miss P. Bennett, R.G.N., S.C.M., Q.N., H.V. (Superintendent)

Royal College of Midwives (Scottish Council)

Miss J. H. Beckett, R.G.N., S.C.M.
Miss P. Bennett, R.G.N., S.C.M., Q.N., H.V.
Miss J. Ritchie, R.G.N., S.C.M.

Royal College of Nursing (Scottish Board)

Miss E. L. Brown, R.G.N., S.C.M., Q.N., H.V.
Miss A. H. Milroy, R.G.N.
Miss M. I. Rattray, R.G.N., S.C.M., H.V.
Miss E. W. Stenhouse, R.G.N., S.C.M.

ROYAL COLLEGE OF PHYSICIANS AND ROYAL COLLEGE OF SURGEONS OF EDINBURGH AND EDINBURGH OBSTETRICAL SOCIETY

D. Miller, Esq., M.D., F.R.C.S.E., F.R.C.P.E., F.R.C.O.G.

ROYAL FACULTY OF PHYSICIANS AND SURGEONS OF GLASGOW

A. D. Telford Govan, Esq., PH.D., M.B., CH.B., F.R.P.P.S.G., F.R.C.P.E., F.R.C.O.G.
D. McKay Hart, Esq., M.B., CH.B., F.R.P.P.S.G., F.R.C.O.O.
H. R. MacLennan, Esq., M.D., P.R.P.P.S.G., F.R.C.O.G.

SCOTTISH COUNCIL OF THE COLLEGE OF GENERAL PRACTITIONERS

Miss M. Esslemont, C.B.E., B.SC., M.A., LL.D., M.B., CH.B., D.P.H.
W. S. Gardner, Esq., M.B., CH.B., F.R.F.P.S.G.
E. V. Kuenssberg, Esq., M.B., CH.B.
Lowell Lamont, Esq., M.B., CH.B.

SCOTTISH REGIONAL COMMITTEE, INSTITUTE OF ALMONERS

Miss W. C. Allen, A.M.I.A.
Miss A. C. MacCallum, A.M.I.A.
Miss E. Stirling, M.A., A.M.I.A.

SCOTTISH STANDING COMMITTEE OF THE ROYAL COLLEGE OF OBSTETRICIANS AND GYNAECOLOGISTS

J. Hewitt, Esq., M.B., CH.B., F.R.F.P.S.G., F.R.C.O.G.
T. N. Macgregor, Esq., F.R.S.E., M.D., F.R.C.S.E., F.R.C.O.G.
D. McKay Hart, Esq., M.B., CH.B., F.R.F.P.S.G., F.R.C.O.G. (Hon. Secretary)

SOCIETY OF MEDICAL OFFICERS OF HEALTH (SCOTTISH BRANCH)

B. R. Nisbet, Esq., M.D., F.R.C.P.E., D.P.H.
Mrs. J. M. Scott, M.B., CH.B., D.P.H.
I. A. G. MacQueen, Esq., M.A., M.D., D.P.H. (Hon. Secretary)

WEST LOTHIAN FEDERATION OF THE SCOTTISH WOMEN'S RURAL INSTITUTES

Mrs. M. Anderson

WEST OF SCOTLAND FEDERATION OF TOWNSWOMEN'S GUILDS

Mrs. V. Marvin

APPENDIX III

Some Statistical Information relating to Maternity Services in Scotland since the Introduction of the National Health Service

	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957 (Provisional)
A. The scope of the work to be covered by the Maternity Services:										
i. Total live births	100,344	95,674	92,530	90,639	90,422	90,913	92,315	92,539	95,313	97,978
ii. Total stillbirths	2,966	2,666	2,557	2,479	2,430	2,308	2,401	2,330	2,329	2,381
iii. Total live and stillbirths	103,310	98,340	95,087	93,118	92,852	93,221	94,716	94,869	97,642	100,359
iv. Live birth rate per 1,000 population	19.687	18.720	18.050	17.722	17.679	17.765	18.019	18.027	18.527	19.0
B. Proportion of domiciliary births:										
i. Total domiciliary births	45,630*	38,280	34,400	31,180	29,400	28,600	28,757	28,820	29,145	29,249
ii. % of total births	44%	39%	36%	33%	32%	31%	30%	30%	30%	29%
iii. Number of cases where midwife only (but no general practitioner) was engaged	Not Available	4,126	1,195	1,771	1,606	1,235	956	815	1,025	880
C. Hospital facilities:										
i. Approved bed complement	2,698	Not Available		2,801	2,779	2,779	2,751	2,838	2,905	2,911
ii. Consultants in obstetrics and gynaecology	Not Available	54	Not Available	60	62	59	64	67	68	69
D. Maternity medical services by medical practitioners:										
i. Total on lists offering maternity services	Not Available	1,995	2,055	2,093	2,165	2,274	2,332	2,367	2,400	2,418
ii. Those offering maternity services only	Not Available	3	4	3	2	3	2	3	1	1

*Includes cases under the Maternity Services (Scotland) Act, 1937, before the Appointed Day

	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957 (Provisional)
E. Local health authority services:										
i. Total number of women attending antenatal‡ clinics of local health authorities	(33,000)†	25,000	25,000	28,000	28,000	28,000	27,000	28,000	28,000	29,000
ii. Total attendances by those women - - - -	Not Available	155,000	147,000	149,000	150,000	154,000	152,000	155,000	163,000	172,000
F. Maternal mortality:										
i. Maternal deaths* - -	160	124	106	99	92	86	70	43	51	46
ii. Rates per 1,000 live and stillbirths - - - -	1.5	1.3	1.1	1.1	1.0	0.9	0.7	0.45	0.5	0.46
G. Infant mortality and stillbirths:										
i. Infant mortality (under 1 year)										
(*a*) infant deaths - -	4,486	3,961	3,569	3,391	3,181	2,800	2,861	2,811	2,727	2,802
(*b*) rate (per 1,000 live births)	44.7	41.4	38.6	37.4	35.2	30.8	31.0	30.4	28.6	29.0
ii. Neo-natal mortality (under 1 month)										
(*a*) deaths - - -	2,521	2,217	2,132	2,019	1,958	1,756	1,904	1,826	1,819	1,960
(*b*) rate (per 1,000 live births)	25.1	23.2	23.0	22.3	21.7	19.3	20.6	19.7	19.1	20
iii. Stillbirths										
(*a*) stillbirths - - -	2,966	2,666	2,557	2,479	2,430	2,308	2,401	2,330	2,329	2,381
(*b*) rate (per 1,000 live and stillbirths) - - -	28.7	27.1	26.9	26.6	26.2	24.8	25.3	24.6	23.9	24.0

‡authorities depending on a Queen's nurse-general practitioner service for antenatal work have made arrangements for women to go to consultant antenatal clinics at hospital. No detailed figures are available.

†including women who attended hospital antenatal clinics before the Appointed Day.

*including deaths from abortion and ectopic gestation.

APPENDIX IV

D.H.S. Circular No. 149/1948

30*th Dec.* 1948

Sir,

Maternity Services in the National Health Service

Co-operation between Local Health Authorities, Regional Hospital Boards and Executive Councils is essential if the various facilities afforded to expectant and nursing mothers are to be properly co-ordinated. In particular, all concerned should know exactly what facilities are available. The enclosed memorandum has accordingly been prepared for the guidance of Authorities, Boards and Councils.

The memorandum describes in some detail the relationship between the various maternity services. It indicates the scope of the information that should be made available in pamphlet form, primarily to general practitioners as the persons most likely to be consulted initially by expectant mothers, but also to other workers in the associated services. The preparation of the pamphlet involves co-operation between Authorities, Boards and Councils. In view of the knowledge and experience of Local Authorities in this field, the Secretary of State suggests that they might undertake the drafting of the pamphlet. Regional Boards and Executive Councils are therefore being asked to send to each Authority the information concerning their services so far as relating to the Authority's area. When the draft of the pamphlet has been completed, it should be passed to the Executive Council for printing and distribution to the general practitioners on the Medical List. Councils are being asked to work out arrangements, in consultation with Authorities and Regional Hospital Boards, for making copies available to other workers in the National Health Service.

The Secretary of State wishes to remind all parties of the desirability of setting up advisory co-ordinating committees, on the lines described in paragraphs 7-9 of D.H.S. Circular 85/1947 of 22nd August 1947. The preparation of the pamphlets advocated in this circular might usefully be considered by such Committees.

A separate copy of this circular has been sent to the Medical Officer of Health.

I am, Sir,

Your obedient Servant,

(Sgd.) R. G. FORREST

The County Clerk,
The Town Clerk (large burghs).

MATERNITY SERVICES IN THE NATIONAL HEALTH SERVICE

1. *Facilities available.* The services of particular interest to expectant mothers are six in number, as follows:

	Responsible Authority
(i) Domiciliary care by general practitioners;	Executive Council
(ii) Supplementary advice by health visitors;	Local health authority
(iii) Services of midwives for home confinements;	Local health authority
(iv) Care and advice at clinics;	Local health authority
(v) Hospital accommodation for institutional confinements;	Regional Hospital Boards working through appropriate Boards of Management
(vi) Specialist services wherever required	Regional Hospital Boards working through appropriate Boards of Management

2. *Initial procedure.* In the great majority of cases in future the first step will no doubt be the diagnosis or confirmation of pregnancy by a woman's family doctor. A provisional decision will then have to be reached whether the confinement is to take place in the woman's own home or in a hospital. Both medical and social factors will enter into this decision, and general practitioners must be in a position to advise their patients about the facilities that will be available according as the one course or the other is chosen. Executive Councils should therefore obtain detailed information appropriate to each locality and issue it to

practitioners on their lists in a pamphlet—a separate pamphlet being prepared for each local health authority area—on the lines of the appendix to this memorandum. (The same information can with advantage he provided to clinics, midwives, and other workers concerned).

3. *Hospital confinements.* If the provisional decision is for a hospital confinement, the practitioner will (unless an arrangement on the plan described in paragraph 7 helow is contemplated) give his patient a note to take to the desired hospital or its associated clinic when she is hooking a bed. The hospital will then he able to let the doctor know whether a bed can be provided; and, later on, the facts regarding her confinement and post-natal findings. If the booking is accepted, then the hospital will be responsible for making a definite arrangement about the woman's ante-natal and post-natal medical supervision. In some cases, especially in towns, it will be possible for the woman to visit an out-patient clinic at the hospital where she is to be confined. Or ante-natal care can be given at an associated local authority clinic, to which a specialist from the hospital is attached. Sometimes a general practitioner can undertake the responsibility, again hy arrangement with and on behalf of the hospital, and with access to a specialist from the hospital where necessary. Whatever the arrangement adopted, there should be provision for keeping an up-to-date record *at the hospital* (as well as at the clinic or in the doctor's surgery) of any facts that should be known when the woman is admitted (perhaps in emergency, hefore the due date) for ante-natal treatment or for confinement. (The whole question of record-keeping is under separate review.)

4. Irrespective of the arrangements for medical care, supplementary advice of a general nature will be availahle to the mother either at a local authority clinic or from a health visitor calling at her home. The woman will be guided to seek such advice by the hospital or its agent responsihle for her ante-natal and post-natal medical care.

5. *Home confinements.* If a home confinement is contemplated, either from choice or because a hed cannot be booked, the family doctor if he does not himself undertake midwifery will help his patient to ohtain the services of another general practitioner. That doctor will become responsible for the woman's medical care so far as relating to conditions arising out of the pregnancy, and will guide her as necessary to seek the various forms of assistance she can obtain from the local authority services. Standing arrangements should he worked out between local authorities and Executive Councils whereby a doctor undertaking midwifery can easily arrange for his patients to obtain the services of a health visitor and a domiciliary midwife, working in co-operation with the doctor to whom they would turn for direction as regards medical care in particular cases. If at any time the doctor desires specialist advice he can obtain that through the hospital organisation in the same way as other forms of specialist advice.

6. Arrangements for a home confinement can he abandoned at any stage if the woman wishes to change to a hospital and a bed is available. Responsibility for ante-natal and post-natal medical care would then be transferred to the hospital which would discharge that responsibility in one of the ways mentioned in paragraph 3 above.

7. *Institutional confinements by general practitioners.* If a woman arranges to be confined, under the care of a general practitioner taking part in the Service, in a nursing home, or in a hospital (whether within the National Health Service or not) to which general practitioners have access without heing " on the staff ", the practitioner can carry on under his maternity medical services contract with the Executive Council. If however a general practitioner proposes to conduct a confinement in a hospital in which he works under an appointment from the Regional Hospital Board, the confinement will rank as a hospital confinement and the arrangements explained in paragraph 3 above will apply. The practitioner in such a case will look to the hospital service for his remuneration, not only in respect of the actual confinement, but also for any ante-natal care given on behalf of the hospital.

8. *Confinement conducted by midwife alone.* There may be some cases where an expectant mother planning a home confinement does not wish to avail herself of the family doctor service, but reports to a clinic. In such cases the clinic will on its own account accept responsibility for ante-natal medical care, and for guiding the woman to the other facilities available. The actual confinement in such cases will be conducted by a midwife acting on her own responsibility, familiar with the patient's history as recorded at the clinic, and calling in medical aid as and when required under C.M.B. rules.

9. *Functions of clinics.* The function of a local authority clinic is twofold. It has to make availahle advice and instruction not of a purely medical nature for all expectant mothers, and medical care (i.e., supervision essentially of a medical nature) for certain classes of expectant mothers—those mentioned in paragraph 8, and those for whom the clinic acts as an agent of the hospital under paragraph 3. Each clinic should be linked with a particular maternity unit in the sense that a specialist working at that hospital is also responsible for specialist consultations required at the clinic; that emergency cases coming to light at the clinic and requiring admission to hospital, for which no previous arrangements have been made, are normally admitted to the associated bospital; and perhaps also that ante-natal medical care of certain patients to be confined at the hospital is provided at the clinic.

10. *The exceptional case.* There may always be a few women who will do nothing at all to prepare for their confinement. In such cases any midwife, doctor or hospital where aid is sought at the last minute will have to cope with the situation as best they can. Primary responsibility should be assumed by the person or hospital applied to, recourse to doctor, specialist, or hospital being sought in the normal way if necessary.

Department of Health for Scotland,
St. Andrew's House, Edinburgh, 1.
30*th December*, 1948

APPENDIX

National Health Service

Maternity Service

Note showing the facilities available
in the area of County Council
Town

For the information of general practitioners in the area of the

.....Executive Council

1. The following doctors undertake the care of home confinements:

Name	*Address*	*Telephone Number*
—	—	—
—	—	—
—	—	—

2. Ante-natal clinics are available as follows:

Clinic	*Area served*	*Day and hour of sessions*	*Medical Officer in charge*
—	—	—	—
—	—	—	—
—	—	—	—

3. Home midwifery, health visiting, home nursing [and domestic help] services are available, under arrangements made by the County or Town Council concerned as follows:

Area served	*Midwifery*	*Address and Telephone Number for Health Visiting*	*Home Nursing*	[*Domestic Help*]
—	—	—	—	—
—	—	—	—	—
—	—	—	—	—

4. The following hospitals are available for institutional confinements:

Hospital	*Associated clinics*	*Obstetrician in charge*	*Address and Telephone Number for applications*	*Arrangements for ante-natal care*
—	—	—	—	—
—	—	—	—	—
—	—	—	—	—

5. Specialist services are available for non-institutional confinements as follows:

Obstetrician	*Consultations (at place) and telephone number for appointments*	*Applications for domiciliary consultations to (address and telephone number)*
—	—	—
—	—	—
—	—	—

APPENDIX V

Proportion of Hospital Confinements, 1957

Region	Hospital beds required for 10 day stay and 4 day interval			Additional antenatal beds required for 8 beds per 1,000 total births	Present obstetric bed complement	Antenatal beds included in obstetric bed complement	Additional hospital beds required for (1) 10 day stay and 4 day interval; (2) for this and for antenatal beds for 8 beds per 1,000 total births					
	For 70% births	For 75% births	For 80% births				For 70% births	For 70% + antenatal	For 75% births	For 75% + antenatal	For 80% births	For 80% + antenatal
Northern -	86	92	99	26 (25.64)	123	None specifically included, but 539 women admitted in 1956	—	—	—	—	—	2
North-Eastern -	241	257	274	72 (71.5)	329	40 + additional beds in peripheral hospitals - -	—	—	—	—	—	17
Eastern - -	194	208	222	58 (57.88)	216	18	—	36	—	50	6	64
South-Eastern -	538	577	612	160	646	140	—	52	—	91	—	126
Western - -	1,566	1,678	1,785	466	*1,598	⅓—½ of total obstetric beds; 10,483 women admitted in 1957 - -	—	434	80	546	187	653

*Includes 59 unstaffed beds at Lennox Castle

APPENDIX VI

Number of Births—Percentage of Hospital Confinement Costs of Home and Hospital Confinements

Local Authority	1956 Number of Births Live and Still	Percentage of Hospital Confinement	1957 Cost of* Home Confinement	Cost of† Hospital Confinement
		%	£ s. d.	£ s. d.
(A) *Areas with High Hospital Confinement Rate*				
Selkirk County	338	97.3	30 9 0	
Bute County	237	94.1	32 7 0	
Banff County	853	92.3	41 9 1	42 8 7
Dumfries Burgh	535	91.4	28 9 10	
Arbroath Burgh	356	89.9	32 17 8	
Peebles County	221	89.6	34 16 1	
(B) *Areas with Low Hospital Confinement Rate*				
Port Glasgow Burgh	550	52.4	34 11 0	
Sutherland County	248	53.2	43 16 4	
Airdrie Burgh	666	55.6	34 3 8	42 8 7
Lanark County	6,556	56.3	32 5 7	
Dumbarton Burgh	697	57.2	30 8 5	
Orkney County	322	58.1	33 10 9	
(C) *Counties of Cities*				
Glasgow	22,461	61.5	34 18 4	
Edinburgh	7,643	82.6	39 16 3	42 8 7
Aberdeen	3,342	86.5	38 12 9	
Dundee	3,510	84.9	34 15 0	

**Made up as follows:*

	£ s. d.
Maternity Medical Service Grant	7 7 0
Home Confinement Grant	4 0 0
Maternity Grant	10 0 0
	£21 7 0
Plus Domiciliary Midwifery from Rating Review	—

†*Made up as follows:*

From D.H.S. Analysis of Running Costs of Hospitals

	£ s. d.
Maternity—National type mean	32 8 7
Plus Maternity Grant	10 0 0
	£42 8 7

APPENDIX VII

1957

Lowest and Highest In-patient Cost per Case—Average Duration of Stay

Hospital	Average Number of Staffed Beds	Average Number of In-patients	Average† In-patient cost	Average duration of Stay
			£ s. d.	Days
Lowest				
Queen's Cross, Aberdeen	14	12	26 8 6	8
Buckreddan, Kilwinning	33	20	26 16 9	7
Fonthill, Aberdeen	18	16	28 18 8	9
Calderbank House, Baillieston	30	28	30 0 5	7
Thorneyflat, Ayr	16	12	31 13 4	6
Dunfermline Maternity	56	48	32 4 6	8
Beckford Lodge, Hamilton	25	16	32 10 3	7
Kincardine O'Neill	11	8	33 0 9	11
Ellon	14	10	34 9 10	9
Highest				
John Martin Hospital, Skye	9	4	92 19 9	18
Ross Maternity	39	31	71 15 6	13
Nicoll, Rhynie	6	2	65 5 9	11
Craigard, Campbeltown	14	6	65 1 8	10
Knoll, Duns	7	4	58 16 5	10
Thornhill, Johnstone	57	41	57 11 3	13
General Pope, Helmsdale	4	2	55 10 2	12
Charleston Maternity, Montrose	19	10	55 8 2	9
Viewpark, Alyth	9	5	52 8 5	9

†From Analysis plus £10 Maternity Grant

APPENDIX VIII

VITAL STATISTICS

The number of live and still births, the live birth rate, tbe stillbirth rate, neo-natal, infant and maternal mortality rates for Scotland for the years 1931 to 1957.

Year	No. of Births (annual averages 1931-1950)		Live birth rate per 1,000 population	Stillbirth rate per 1,000 live and stillbirths	Deaths under four weeks per 1,000 live births	Deaths under 1 year per 1,000 live births	Maternal Deaths including deaths from abortion and ectopic gestation	Maternal Mortality rate per 1,000 total live and stillbirths
	Live	Still						
1931-35 - -	89,306	—	18.207	—	36.8	80.8	548	6.13
1936-40 - -	87,734	—	17.557	—	36.9	75.8	424	4.83
1941-45 - -	91,593	3,393	17.766	35.7	33.8	67.7	345	3.6
1946-50 - -	101,222	3,047	19.806	29.2	26.1	47.3	173	1.70
1951 - - -	90,639	2,479	17.722	26.6	22.3	37.4	99	1.06
1952 - - -	90,422	2,430	17.679	26.2	21.7	35.2	92	0.99
1953 - - -	90,913	2,308	17.765	24.8	19.3	30.8	86	0.92
1954 - - -	92,315	2,401	18.019	25.3	20.6	31.0	70	0.74
1955 - - -	92,539	2,330	18.027	24.6	19.7	30.4	43	0.45
1956 - - -	95,313	2,329	18.527	23.9	19.1	28.6	51	0.5
1957* - - -	97,978	2,381	19.0	24.0	20.0	29.0	46	0.46

*Provisional figures

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